

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G253 12/3/59 iwk

12180

12212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balts.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home - 31 Wade Ave. Catonsville Md. 28,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frank H. Alban</i>		4. DATE OF DEATH Month Day Year <i>11 24 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/5/199</i>
9. AGE (In years last birthday) <i>60</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocery store owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Harry A. Alban</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Gordon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Geo. F. Alban</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C.V. Disease</i> DUE TO <i>149</i> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-13</i> , 19 <i>59</i> , to <i>11-24</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11-23</i> , 19 <i>59</i> , and that death occurred at <i>3 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James Stowes</i> M.D.		ADDRESS (Street, city or town, state) <i>Catonsville</i> DATE SIGNED <i>11-25</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/27/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>		22d. LOCATION (City, town, or county) (State) <i>Balts. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>MacNabb & Son 28</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kneib</i>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12213

CERTIFICATE OF DEATH

Reg. Dist. No.

12181

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rayville</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>B.</u> Last <u>Almony</u>				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1885</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tap Room</u>		11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.-</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Benjamin Almony</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Rosier.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>213-28-1758</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma with metastases</u> 191.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25, 1959</u> , to <u>11-7-1959</u> , that I last saw the deceased alive on <u>11-7-1959</u> , and that death occurred at <u>4:50 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Robinson,</u>				ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u> DATE SIGNED <u>11-14-59</u>			
PHYSICIAN'S NAME (Type) <u>R. ROBINSON</u>				New Freedom, Pa.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial.</u>		22b. DATE THEREOF <u>11/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stablersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Fortenstein,</u>				ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cashin & Kneass</u>			

12131

10-30-54

12131

10-30-54



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12214

CERTIFICATE OF DEATH

Reg. Dist. No.

12182

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRADSHAW				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHEFFERS ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Henry Appel				4. DATE OF DEATH Nov. 6 1959			
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 12, 1892	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PREFITTER RETIRED				10b. KIND OF BUSINESS OR INDUSTRY ARSENAL		11. BIRTHPLACE (State or foreign country) BALTO Co. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN H. APPEL				14. MOTHER'S MAIDEN NAME EMMA HITCHCOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 220-207497			
17. INFORMANT JOHN H APPEL RFD 3 BELAIR ACRES.				Address BELAIR MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Nov. 6, 1959 , to Nov. 6, 1959 , that I last saw the deceased alive on Nov. 6, 1959 , and that death occurred at 8 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Tyson M.D.				ADDRESS (Street, city or town, state) Kingsville, Md.			
PHYSICIAN'S NAME (Type) William A. Tyson				DATE SIGNED 11-6-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-9-59	22c. NAME OF CEMETERY OR CREMATORY FORK METHODIST		22d. LOCATION (City, town, or county) FORK MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Sassahn Funeral Home				ADDRESS 7401 Belair Road		24a. REC'D BY REGISTRAR NOV 12 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

1. Name of deceased: John William Smith

2. Sex: Male

3. Age: 45

4. Date of birth: March 15, 1889

5. Place of birth: St. Louis, Mo.

6. Date of death: April 10, 1934

7. Place of death: Home, 1234 Main St., Baltimore, Md.

8. Cause of death: Myocardial infarction

9. Duration of illness: 2 weeks

10. Name of physician: Dr. J. H. Jones

11. Name of funeral home: None

12. Name of informant: John A. Smith

13. Address of informant: 1234 Main St., Baltimore, Md.

14. Signature of informant: [Signature]

15. Signature of physician: [Signature]

16. Signature of funeral home: [Signature]

17. Signature of informant: [Signature]

18. Signature of informant: [Signature]

19. Signature of informant: [Signature]

20. Signature of informant: [Signature]

21. Signature of informant: [Signature]

22. Signature of informant: [Signature]

23. Signature of informant: [Signature]

24. Signature of informant: [Signature]

25. Signature of informant: [Signature]

26. Signature of informant: [Signature]

27. Signature of informant: [Signature]

28. Signature of informant: [Signature]

29. Signature of informant: [Signature]

30. Signature of informant: [Signature]

31. Signature of informant: [Signature]

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74. Signature of informant: [Signature]

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81. Signature of informant: [Signature]

82. Signature of informant: [Signature]

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91. Signature of informant: [Signature]

92. Signature of informant: [Signature]

93. Signature of informant: [Signature]

94. Signature of informant: [Signature]

95. Signature of informant: [Signature]

96. Signature of informant: [Signature]

97. Signature of informant: [Signature]

98. Signature of informant: [Signature]

99. Signature of informant: [Signature]

100. Signature of informant: [Signature]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 6 Film G252 11-16-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Winter an Extended		d. STREET ADDRESS 467 Commonwealth Ave	
3. NAME OF DECEASED (Type or print) Alice Elizabeth Bacon		4. DATE OF DEATH Nov 5 1959	
5. SEX F	6. COLOR OR RACE Col W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 6 1924
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Colored	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rennus Bacon		14. MOTHER'S MARRIED NAME Lena Crawford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 48-17	
17. INFORMANT Rennus Bacon		18. ADDRESS OF INFORMANT Catonsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov 6, 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-59	
22c. NAME OF CEMETERY OR CREMATORY Western Star Cem.		22d. LOCATION (City, town, or county) (State) Catonsville MD	
23. FUNERAL DIRECTOR'S SIGNATURE C. Halstead ADDRESS 918 Druid Hill Ave.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

1123

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL INVESTIGATION

NOV 19 1918
RECEIVED

[Faint, mostly illegible handwritten text and markings on a form with horizontal lines. Some legible fragments include:]

[Top section:]
Name of Patient
Age
Sex
Occupation
Address
City
State
Date of Admission
Date of Discharge
Cause of Death
Place of Death
Place of Burial
Name of Physician
Name of Hospital
Name of Nurse
Name of Attending Physician
Name of Pathologist
Name of Microscopist
Name of Bacteriologist
Name of Chemist
Name of Radiologist
Name of X-ray Technician
Name of Pathologist
Name of Microscopist
Name of Bacteriologist
Name of Chemist
Name of Radiologist
Name of X-ray Technician

[Bottom section:]
Signature of Physician
Signature of Hospital
Signature of Nurse
Signature of Attending Physician
Signature of Pathologist
Signature of Microscopist
Signature of Bacteriologist
Signature of Chemist
Signature of Radiologist
Signature of X-ray Technician

RECEIVED
NOV 19 1918
BUREAU OF MEDICAL INVESTIGATION
U. S. DEPARTMENT OF HEALTH

12216

CERTIFICATE OF DEATH

12184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCHARN MD</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AUGSBURG Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. MD</u> d. STREET ADDRESS <u>42 S. Polaski</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LOUISE</u> First <u>A SENDORF</u> Middle <u>BAUSMAN</u> Last 4. DATE OF DEATH <u>NOV.</u> Month <u>4,</u> Day <u>1959</u> Year				5. SEX <u>7</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/21/1886</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Albert T. ASENDORF</u>				14. MOTHER'S MAIDEN NAME <u>Thiemeyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Records AUGSBURG Home</u> Address <u>6811 CAMPFIELD RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>(2) Hypertensive Heart Disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Obesity</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10 -</u> , 19 <u>58</u> , to <u>Nov. 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 4 -</u> , 19 <u>59</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D. <u>4108 Liberty St. Baltimore Md</u>				DATE SIGNED <u>11-6-59</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers -</u>				<u>4108 Liberty St. Ave. Balt. Md.</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 6 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LODON PK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. A. Heemann</u> ADDRESS <u>6067 Harford Rd.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>NOV 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

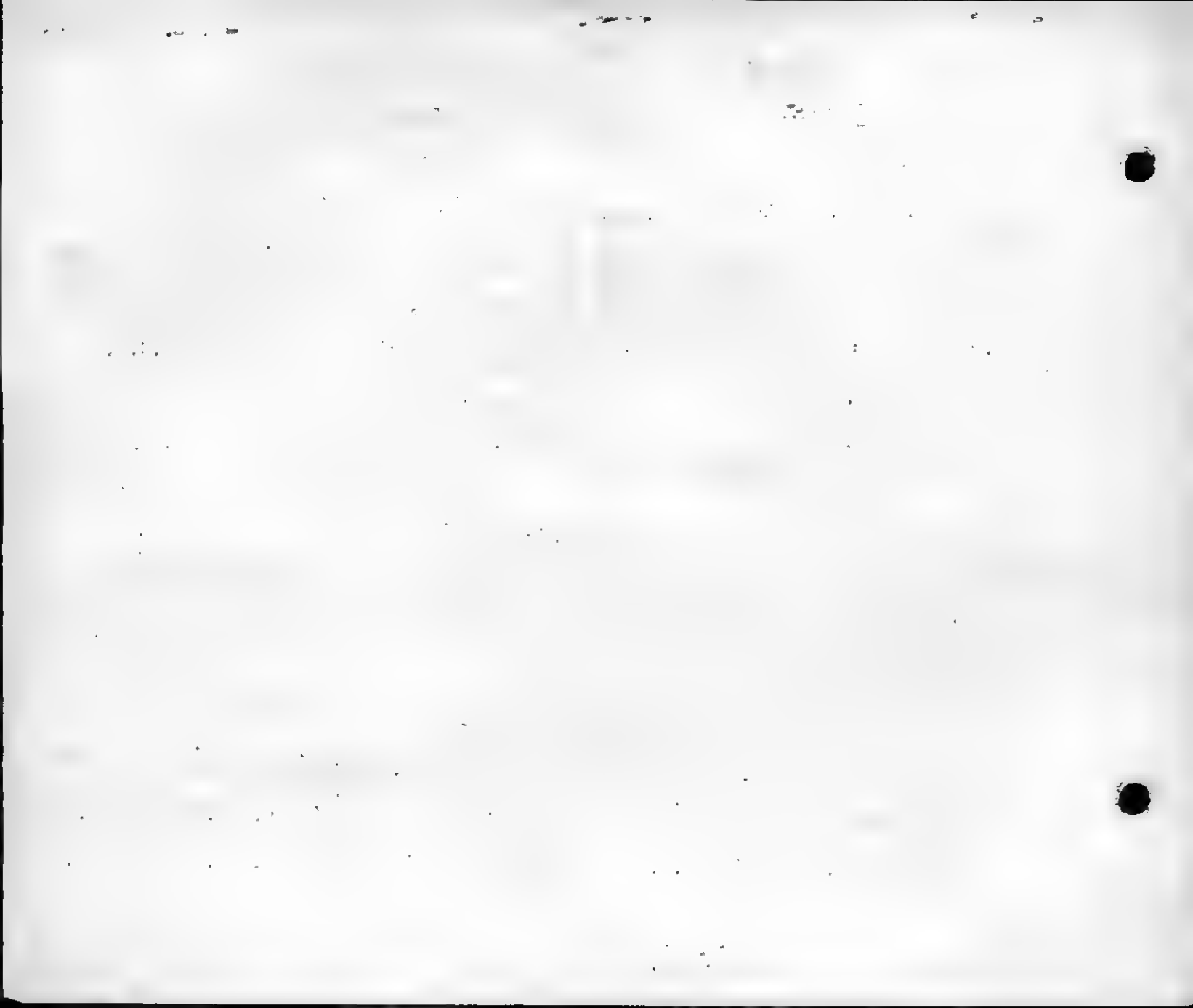
Reg. Dist. No.

12217

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE MARYLAND b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 79 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4 (17)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1729 BOLTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle A. H. Last BECK				4. DATE OF DEATH Month NOVEMBER Day 22 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH OCTOBER 11, 1919	
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 2 Days 3 Hours 0 Min 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT				10b. KIND OF BUSINESS OR INDUSTRY INSURANCE AGENCY		11. BIRTHPLACE (State or foreign country) UTAH	
13. FATHER'S NAME HARRY M. BECK				14. MOTHER'S MAIDEN NAME ELOISE MC BRINE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. WW-11		INFORMANT Address CLIN REC VAH BALTO MD FT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) NEPHRITIS, SUBACUTE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Edema of lungs and brain.							INTERVAL BETWEEN ONSET AND DEATH 2 to 3 Days 8 Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from September 4, 1959 to November 22, 1959 and that death occurred at 1:10 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Crawford				ADDRESS (Street, city or town, state) VAH, BALTIMORE 18, MD. FT. HOWARD, MD. DATE SIGNED 11/23/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.				VAH, BALTIMORE 18, MD. FT. HOWARD, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-25-59		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WM ODDK-BLIGHT INC				ADDRESS 6009 Harford Road Baltimore Md		24a. REC'D BY REGISTRAR NOV 27 59 DATE	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

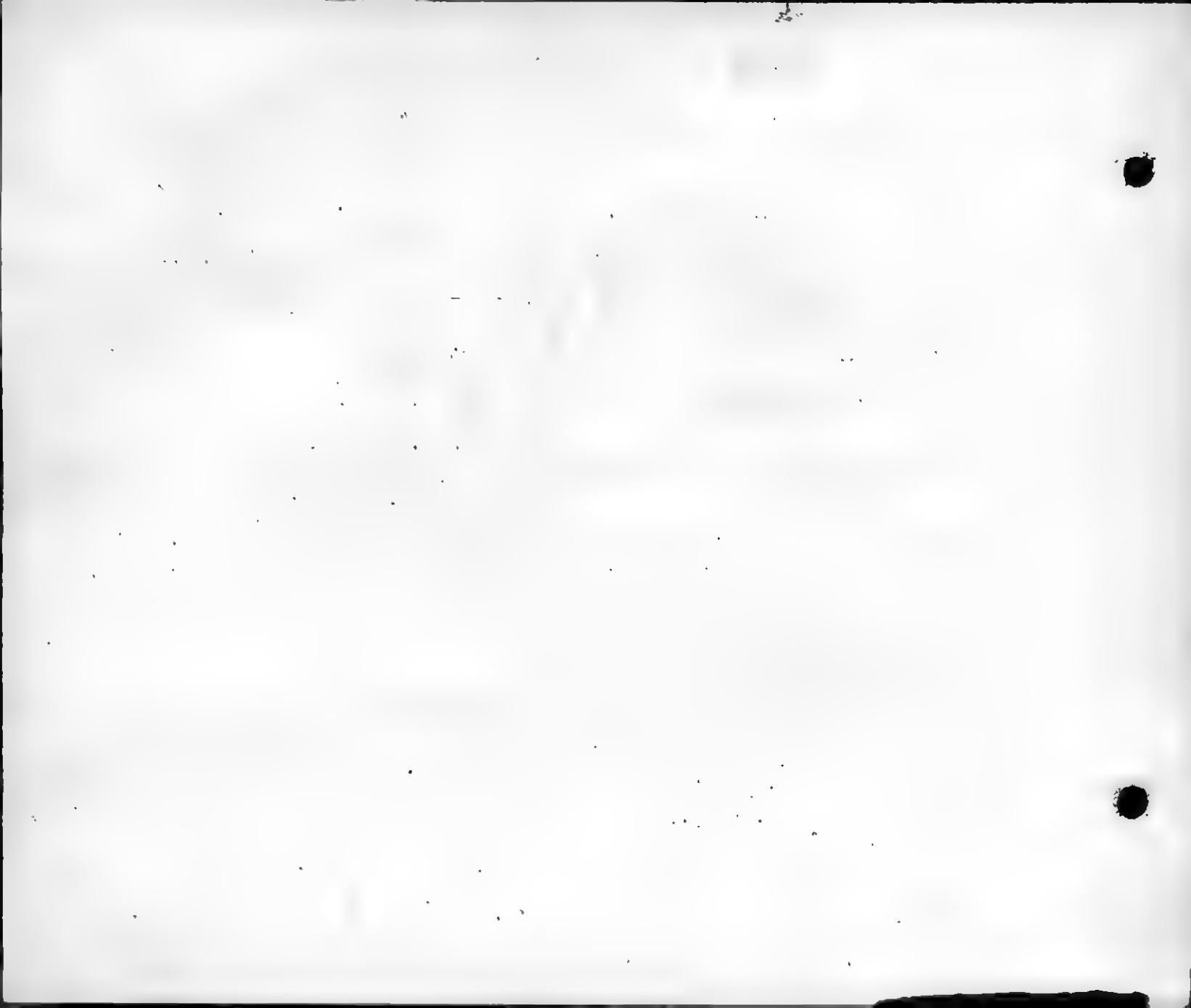
CERTIFICATE OF DEATH

Reg. Dist. No. **12186**

12218

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 4,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1604 Thetford Rd.</u>		d. STREET ADDRESS <u>1604 Thetford Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Mildred</u> Last <u>Bergmann</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>9,</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Schaefer</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Toufel</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT <u>Mrs Wm. F. Church</u>	
Address <u>same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis & Insufficiency</u> (c) <u>Diabetes Mellitus</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>5 yrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10-1951</u> to <u>11-9-1959</u> that I last saw the deceased alive on <u>11-9-1959</u> and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Siver</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3105 N. Charles St. Baltimore, Md. 11-9-59</u>	
PHYSICIAN'S NAME (Type) <u>B. H. Siver</u>		22a. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12219

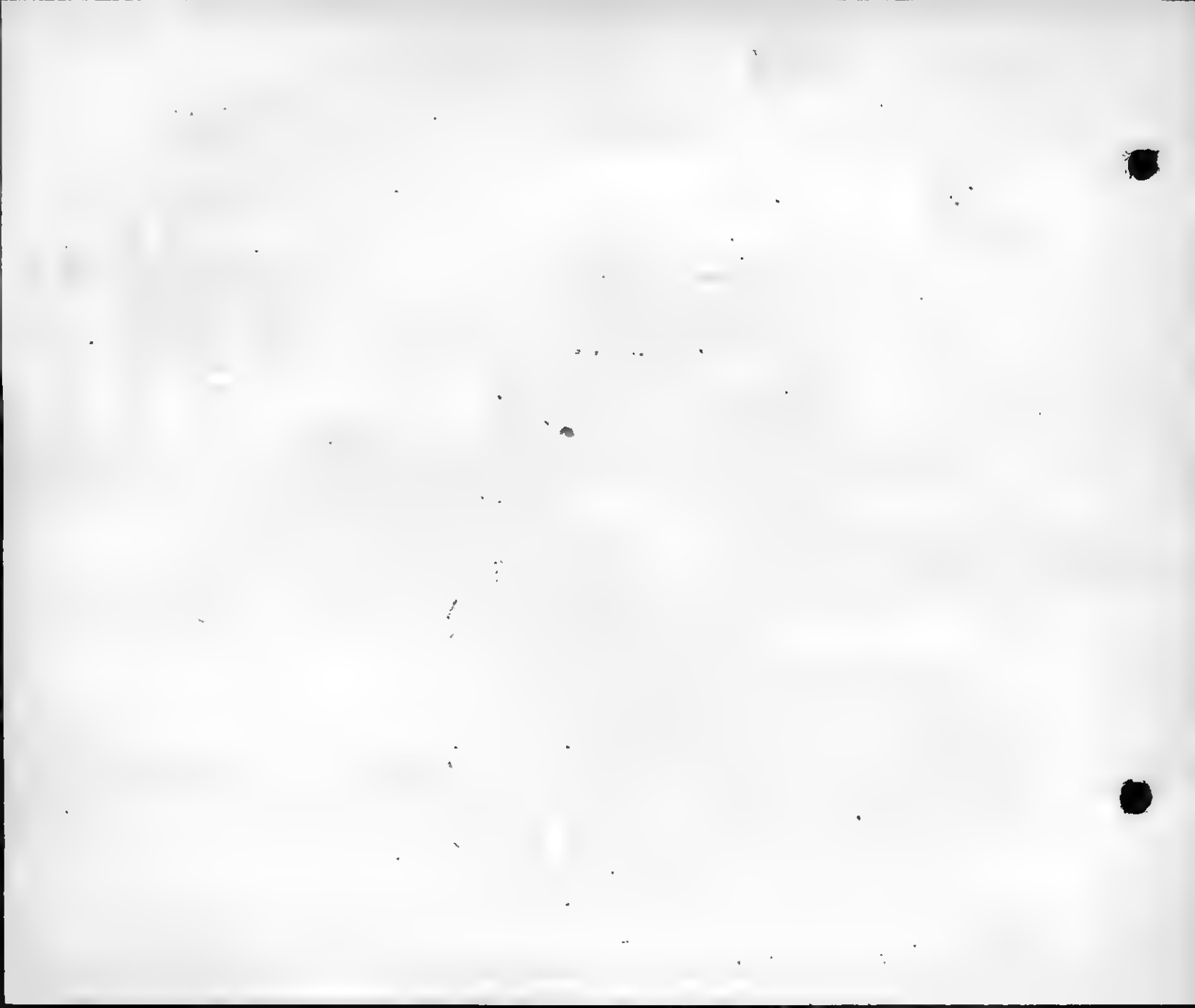
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Grady North Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ELIZABETH C. BERLAU</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/1/69</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Conrad Beyer</i>		14. MOTHER'S MAIDEN NAME <i>Wilhemina</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>E. Brady</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF RECTUM - METASTASIS TO LYMPH GLANDS</i> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>13 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ARTERIO SCLEROSIS; ARTERIOSCLEROTIC HEART DIS; PHLEBITIS</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>APR. 24</i> , 1958, to <i>NOV 30</i> , 1959, that I last saw the deceased alive on <i>NOV. 29</i> , 1959, and that death occurred at <i>2:10 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6348 FREDERICK RD. BALTIMORE 28, MD.</i> DATE SIGNED <i>12/1/59</i>			
ACTUAL SIGNATURE <i>John N. Snyder</i> M.D.		DATE SIGNED <i>12/1/59</i>	
PHYSICIAN'S NAME (Type) <i>JOHN N. SNYDER, M.D.</i>		<i>BALTIMORE 28, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/3/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Matthews</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 3 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12188

12220

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe 51</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgway Manor</u>				d. STREET ADDRESS <u>5712 First Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Eda V.</u> Middle <u>Bowen</u> Last <u></u>				4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25 1888</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-22-9576</u>		17. INFORMANT Address <u>Thomas Carlin 5708 First Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>July 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 10</u> , 19 <u>59</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Brown, Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>1267 Fairview Ave Baltimore</u>			
DATE SIGNED <u>Nov 24 1959</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc. 1324 Sulphur Spring Rd</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

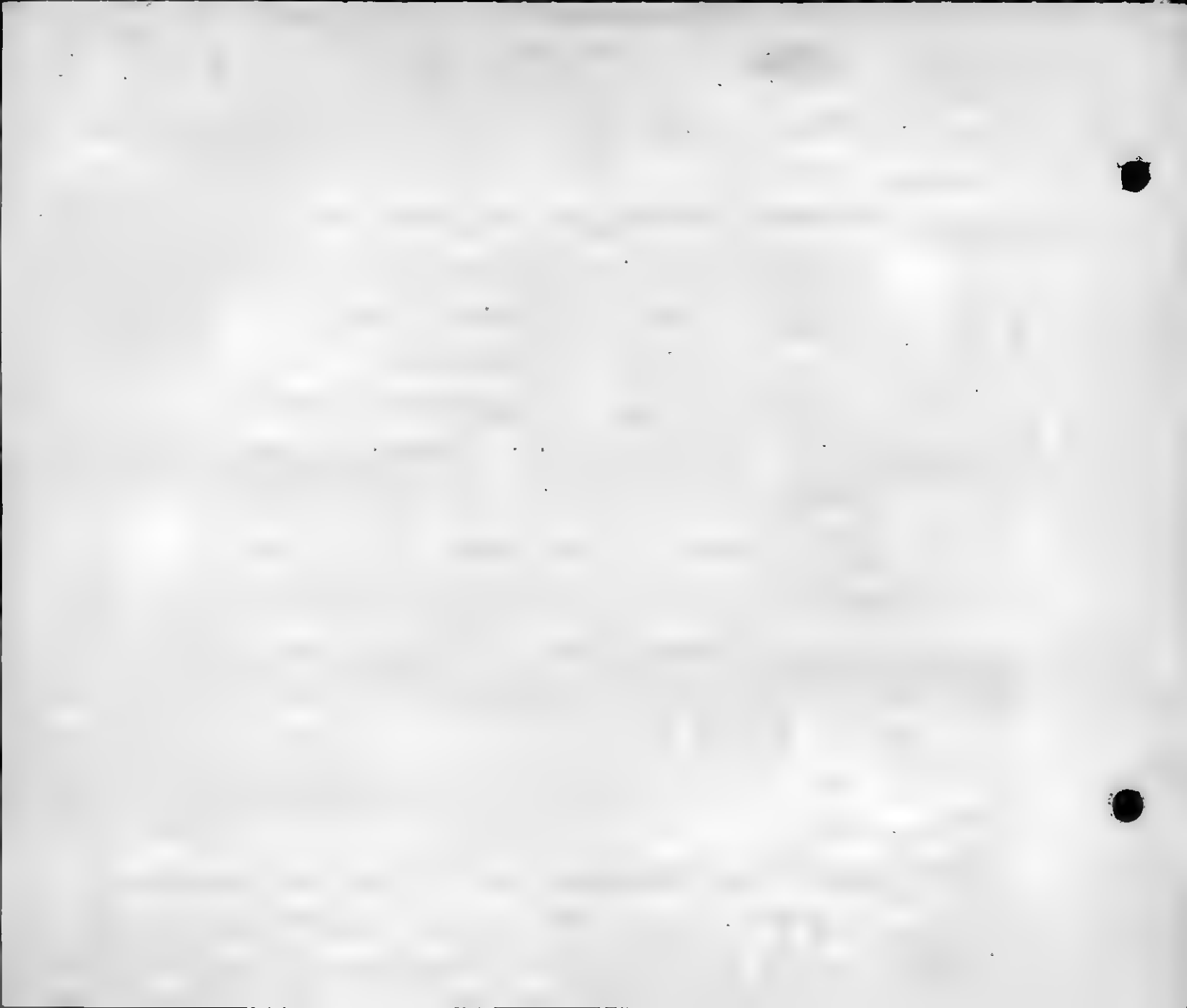
12195

CERTIFICATE OF DEATH

12189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1924 Maxwell Avenue		d. STREET ADDRESS 1924 Maxwell Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES M. BRANDT		4. DATE OF DEATH Month Day Year November 29, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1912
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Piechocki		14. MOTHER'S MAIDEN NAME Pelagia Swieczikowska	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212071064	
17. INFORMANT Mr. T. Piechocki		Address 1924 Maxwell Ave 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Crisis - Vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-12 , 19 56 to July 7 , 19 59 that I last saw the deceased alive on July 7 , 19 59 , and that death occurred at 4:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lester Lebo M.D. 1801 Eastern Pl. Balto 17, Md		DATE SIGNED 11/30/59	
PHYSICIAN'S NAME (Type) LESTER LEBOWITZ			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City or town, county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. F. SADOWSKI & SONS, 1808 EASTERN AVENUE		24. REC'D BY REGISTRAR DEC 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

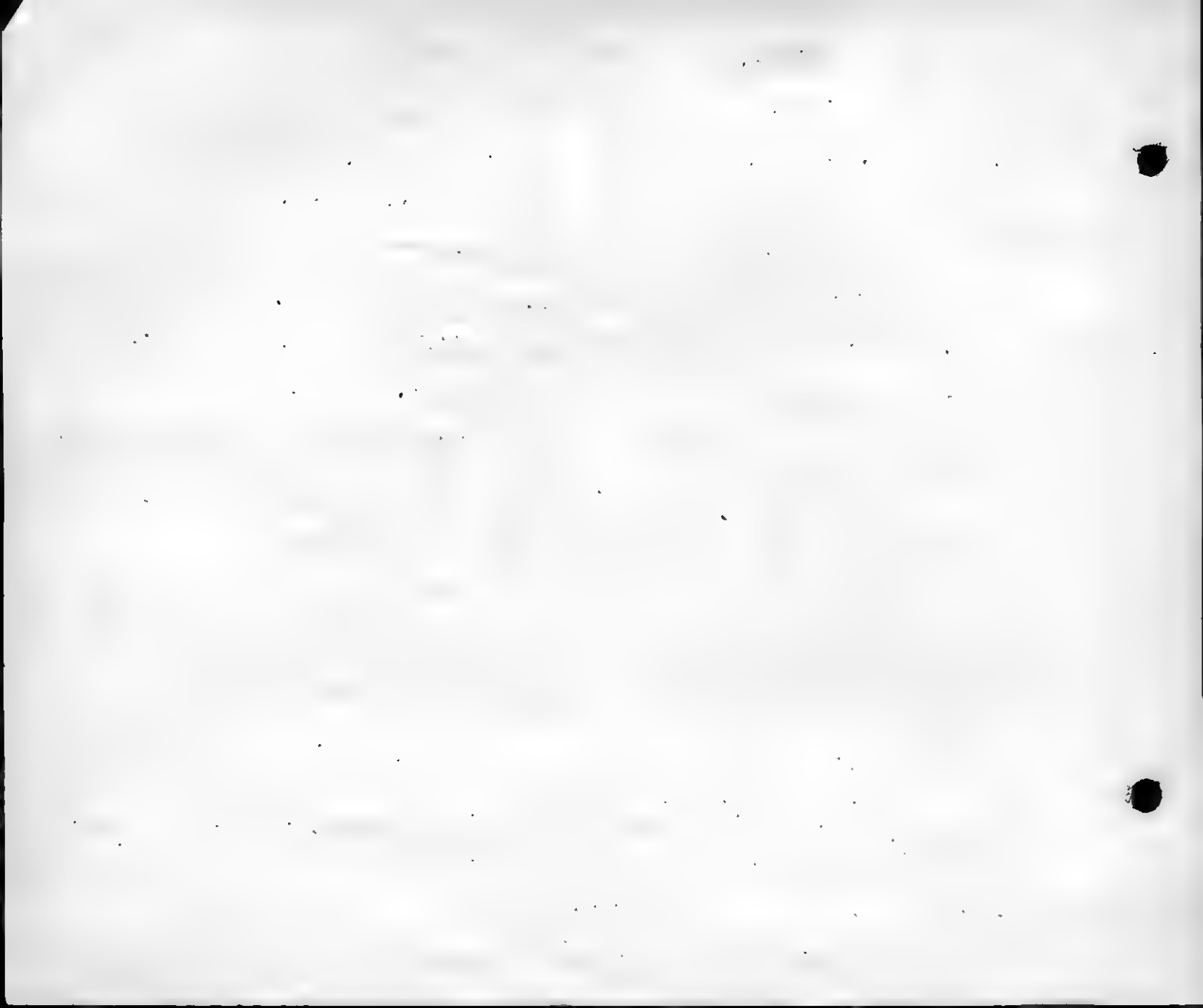
Reg. Dist. No. 12190

12221

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FOREST HAVEN NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK BRANDT		4. DATE OF DEATH Month Day Year NOV 4 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1870
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) BALTO. CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CARL BRANDT		14. MOTHER'S MAIDEN NAME CAROLINE HAGEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address BRANDT MILLER 3306 FOSTER AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE 422.1 DUE TO CHRONIC CIRCULATORY COLLAPSE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SENILITY DUE TO (c) SENILITY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1 , 19 59 , to 11/4 , 19 59 , that I last saw the deceased alive on 11/4 , 19 59 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5840 EDWARDS AVE BALTO MD 11/4/59			
ACTUAL SIGNATURE John H. Shaw M.D.		PHYSICIAN'S NAME (Type) JOHN H. SHAW MD BALTO. MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-7-59	
22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL CEM.		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Forest Haven Nursing Home ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 12 1959	
		24b. REGISTRAR'S SIGNATURE Carlton S. Kinn	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



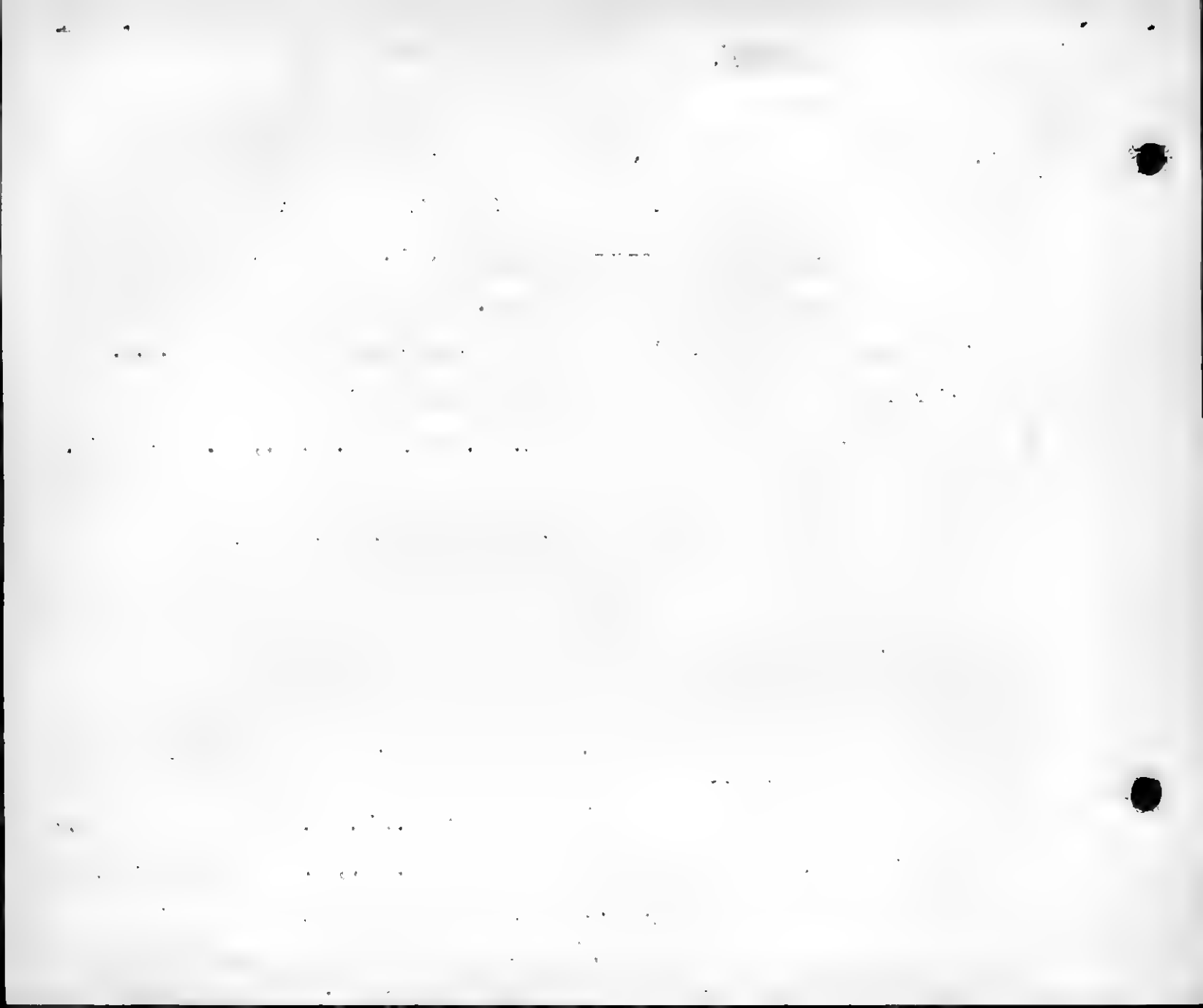
12222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Howard		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle ----- Last BRIGHT, JR.		4. DATE OF DEATH Month November Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1917
9. AGE (In years lost birthday) yrs. 42		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (State or foreign country) Camden, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander		14. MOTHER'S MAIDEN NAME Amelia Tillit	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 231-09-1524	
17. INFORMANT Clin. Rec. VAH Balto. 18, Md., Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x INANITION DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ADENOCARCINOMA OF PANCREAS WITH METASTASIS DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 14, 1959 to November 29, 1959 , and that death occurred at 4:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Walter C. Goldstein, M.D.		M.D. VAH Balto., Md., Ft. Howard Division 11/29/59	
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, MD		VAH Balto., Md., Ft. Howard Division 11/29/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 6, 1959	22c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery	22d. LOCATION (City, town, or county) (State) Camden, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Russ		24a. REC'D BY REGISTRAR DEC 1 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

JOSEPH L. RUSS FUNERAL HOME, 2222 W. NORTH AVE., BALTO., MD.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12192

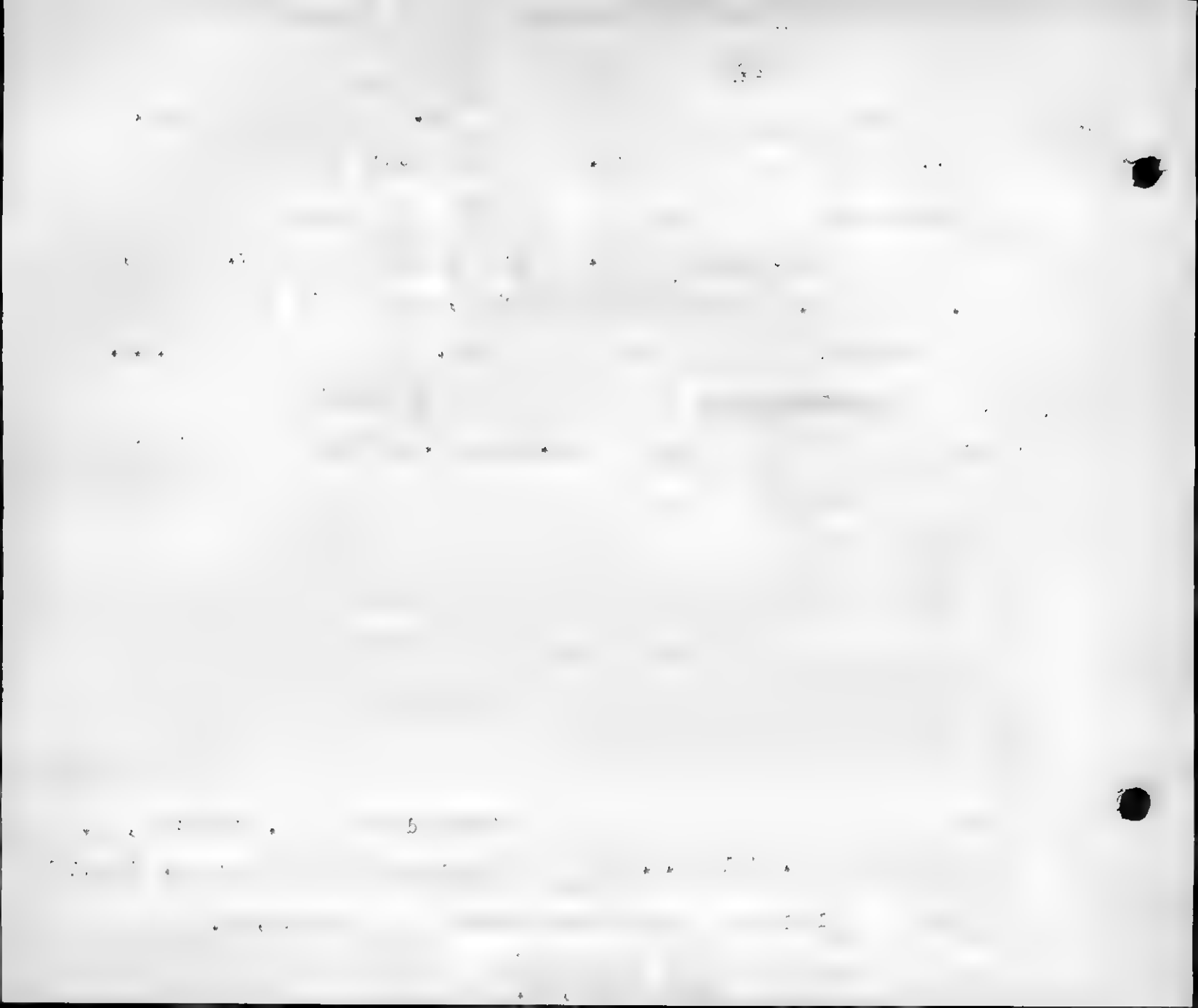
12223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 26 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greens Lane		d. STREET ADDRESS Winans Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Katherine A. Brodbeck		4. DATE OF DEATH Month Nov. Day 18, Year 19 59	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> Single	8. DATE OF BIRTH April 1, 1881
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noses Daffensperger		14. MOTHER'S MAIDEN NAME Susan Bankert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George R. Brodbeck		Address Winans Road Box 556	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) Art. Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 months 2 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19 49 to November 18 19 59 , that I last saw the deceased alive on November 16 19 59 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Rd & Walker Ave. Pikesville, Md. DATE SIGNED 10/19/59			
ACTUAL SIGNATURE James A. Miller M.D.		M.D. Reisterstown Rd & Walker Ave. Pikesville	
PHYSICIAN'S NAME (Type) James A. Miller M.D.		Reisterstown Road & Walker Ave. Pikesville	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/21/59	22c. NAME OF CEMETERY OR CREMATORY Stone Church Cemetery	22d. LOCATION (City, lawn, or county) (State) Brodbeck, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Road	
24a. REC'D BY REGISTRAR NOV 23 59		24b. REGISTRAR'S SIGNATURE Arthur S. Broad	
DATE Randallstown, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

12193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 572 Catonsville, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1200 Tugwell ROAD Dr.		d. STREET ADDRESS 1200 Tugwell ROAD Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle F. Last Brooks		4. DATE OF DEATH Month Nov. Day 21 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert J. Price		14. MOTHER'S MAIDEN NAME Sallie Mongen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Philip D. Brooks		Address 1200 Tugwell ROAD Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1958 to Nov. 1959 that I last saw the deceased alive on Nov. 18 , 1959 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 Mallow Hill Rd. DATE SIGNED 			
ACTUAL SIGNATURE Lee J. Gaver M.D.			
PHYSICIAN'S NAME (Type) XX Lee Gaver, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-59	
22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR DATE NOV 24 '59	
ADDRESS 4107 Wilkens Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

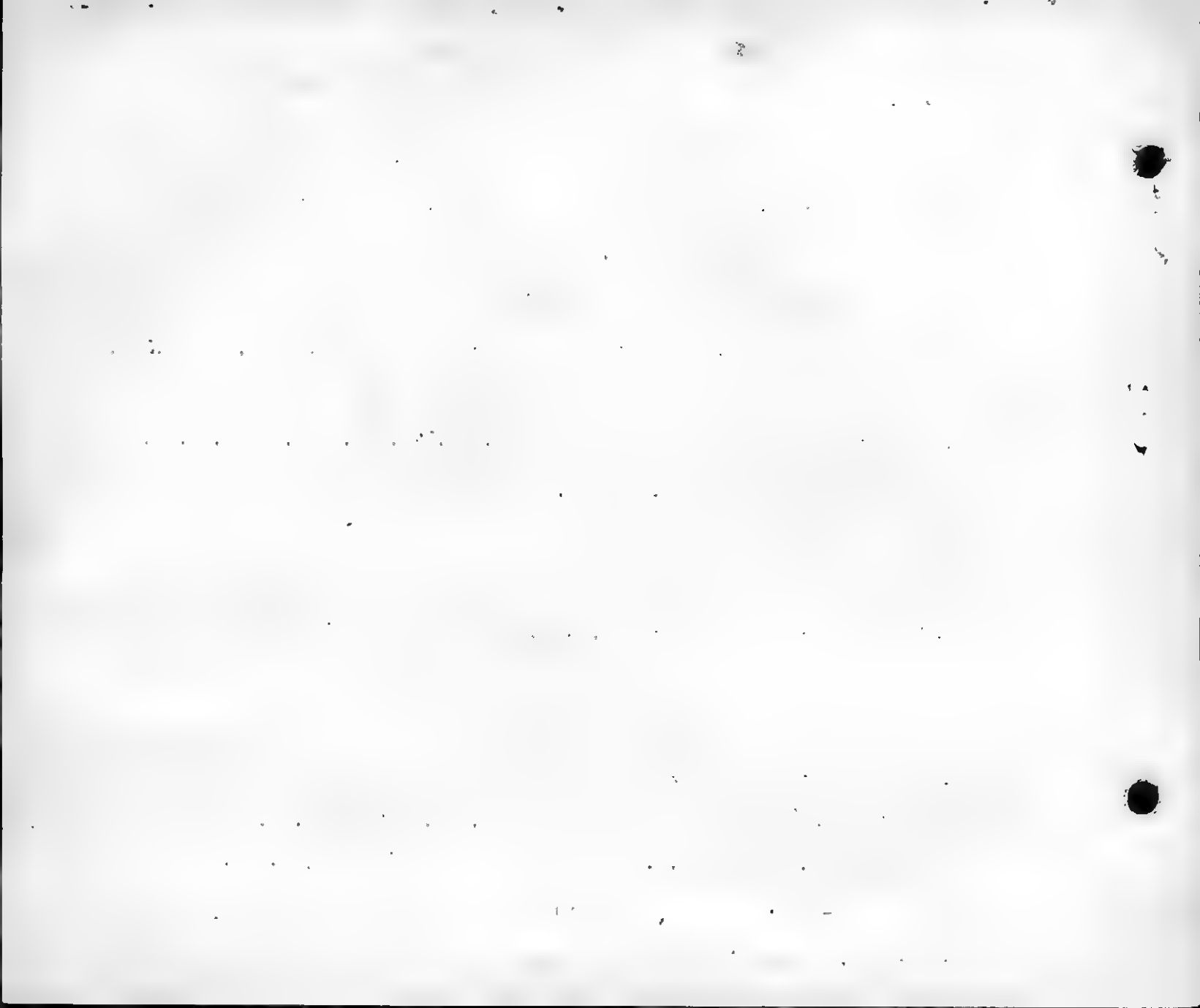
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 57 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3207 Hilltop Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last BROOKS		4. DATE OF DEATH Month November Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1874
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min 85	11. IF UNDER 24 HRS Months 85 Days 85 Hours 85 Min 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cloth Folder		10b. KIND OF BUSINESS OR INDUSTRY Cloth Bleaching Factory Fall River, Mass.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN BROOKS		14. MOTHER'S MAIDEN NAME MARY GLYNN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 029-03-4232	
17. INFORMANT CLIN. REC. VET. ADM. HOSP. BALTO. MD. FT. HOWARD DIV		Address CLIN. REC. VET. ADM. HOSP. BALTO. MD. FT. HOWARD DIV	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c) 491X		INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) STATUS POST PROSTATECTOMY FOR BHP. GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that X attended the deceased from September 21, 1959 to November 17, 1959 and that death occurred at 1:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, BALTO, MD. FT. HOWARD DIV DATE SIGNED 11/17/59			
ACTUAL SIGNATURE Norris L. Newton		M.D. VET. ADM. HOSP. BALTO. MD. FT. HOWARD DIV	
PHYSICIAN'S NAME (Type) NORRIS L. NEWTON, M.D.		VA HOSPITAL, BALTO, MD. FT. HOWARD DIV.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 11-18-59	22c. NAME OF CEMETERY OR CREMATORY St. Patrick's	22d. LOCATION (City, town, or county) (State) Fall River, Massachusetts
23. FUNERAL DIRECTOR'S SIGNATURE Donnelly Funeral Home, Fall River, Massachusetts		24a. REC'D BY REGISTRAR NOV 19 59	24b. REGISTRAR'S SIGNATURE Arthur S. Knecht

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W.M. Cook, Inc., 1217 St Paul St



12226
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 CATONSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES		d. STREET ADDRESS 5 ARTHUR AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha E Brown		4. DATE OF DEATH Month Day Year 11 11 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 1, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME SAMUEL KEEN		14. MOTHER'S MAIDEN NAME KEZIAH KNIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-05-5061	
17. INFORMANT MR. JOHN H. BROWN		Address CATONSVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis DUE TO (c) Hypertensive Cardio-Vascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 9 d. 10 p. 15 p.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-6-1956 , to 11-11-1959 , that I last saw the deceased alive on 11-11-1959 , and that death occurred at 7:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6209 Frederick Ave. 11-11-59 M.D. Baltimore-28, Md.			
ACTUAL SIGNATURE Wilmer K. Gallager		PHYSICIAN'S NAME (Type) Wilmer K. Gallager	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-14-1959	22c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM. WOODLAWN, MD.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Edwin S. Catonsville		24a. REC'D BY REGISTRAR NOV 16 59	
24b. REGISTRAR'S SIGNATURE Edwin S. Catonsville		24c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12196

Reg. Dist. No.

12227

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 35 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Dean Avenue				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
				f. STREET ADDRESS 17 Dean Avenue			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Slade Last Brown				4. DATE OF DEATH Month November Day 4 Year 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2 1887	
				9. AGE (In years) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Church Janitor				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Brown				14. MOTHER'S MAIDEN NAME Alice Flater			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Elmer Randall Reisterstown Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lung, rt. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral inguinal hernias, Bilateral blindness						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
				20f. (City or town) none		(County) (State)	
21. I certify that I attended the deceased from 9-30-53 , 19____, to 11-4-59 , 19____, that I last saw the deceased alive on 11-4-59 , 19____, and that death occurred at 7 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6 Hanover Rd. 11-6-59							
ACTUAL SIGNATURE D. D. Caples				M.D. 6 Hanover Rd.			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 7 1959		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) San Antonio, Texas	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Brown				24a. REC'D BY REGISTRAR NOV 9 '59		24b. REGISTRAR'S SIGNATURE Clifton S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - RUXTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - RUXTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1404 Maywood Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle L. Last BROWN				4. DATE OF DEATH Month NOV Day 15 Year 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1892	
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR: Months 67		11. IF UNDER 24 HRS: Days 67		12. IF UNDER 24 HRS: Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stonewall Jackson Brown				14. MOTHER'S MAIDEN NAME Maggie A. Massey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Mrs. Lillian M. Brown, 1404 Maywood Avenue			
17. INFORMANT Mrs. Lillian M. Brown, 1404 Maywood Avenue				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANGIO SARCOMA OF GREATER OMENTUM 128X DUE TO WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH 5 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---				20g. (County) ---		20h. (State) ---	
21. I certify that I attended the deceased from JUNE 19, 1959 to NOV 15, 1959 , that I last saw the deceased alive on 11-15, 1959 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10 W. Madison St DATE SIGNED Arthur E. Little							
ACTUAL SIGNATURE Luther E. Little M.D. 10 W. Madison St							
PHYSICIAN'S NAME (Type) LUTHER E. LITTLE							
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF 11-18-59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Zone 4				ADDRESS ---		24a. REC'D BY REGISTRAR NOV 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Little							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12229

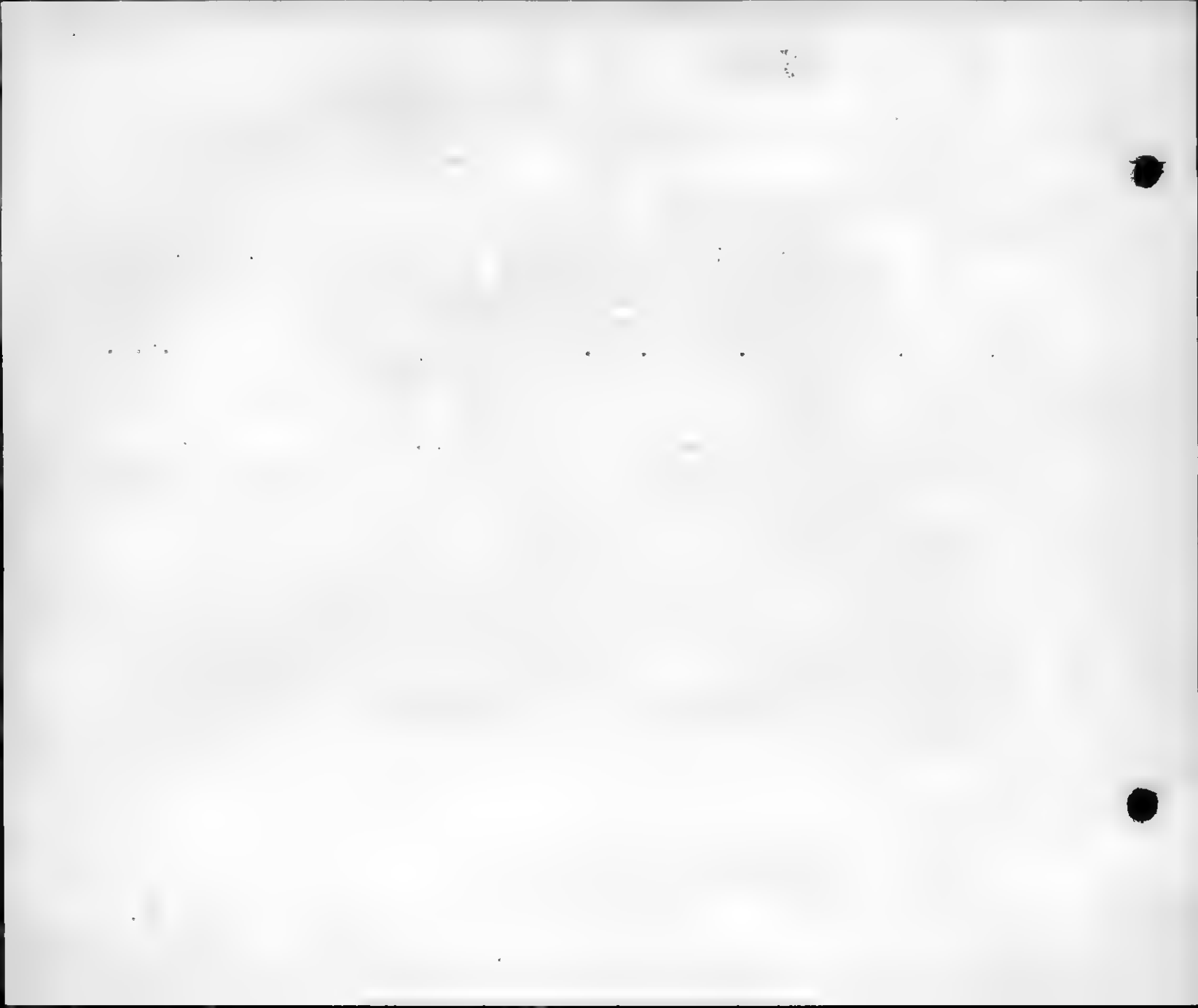
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4				c. LENGTH OF STAY IN lb 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR NITUTION Towson Convalescent Home				e. STREET ADDRESS none			
3. NAME OF DECEASED (Type or print) First Edmund Middle Thompson Last Bryan				4. DATE OF DEATH Month 11 Day 11 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-1884		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief plumbing insp.		10b. KIND OF BUSINESS OR INDUSTRY Balto. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edmund Bryan				14. MOTHER'S MAIDEN NAME Anna Ambrose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-32-0310		INFORMANT Sanders K. Bryan		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiac Vasculodisium 443X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov. 10 , 19 56 , to Nov. 11 , 19 59 that I lost saw the deceased olive on Nov. 10 , 19 57 , and that death occurred at 12 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. M. France M.D.				ADDRESS (Street, city or town, state) Parkton, Md.		DATE SIGNED 11/12/59	
PHYSICIAN'S NAME (Type) A. M. FRANCE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-59		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore 14, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thomas	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

12199

Reg. Dist. No.

12230

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. STREET ADDRESS 3974 DOFFIELD AVE	
3. NAME OF DECEASED (Type or print) First LILLIE Middle MAY Last BURDETTE		4. DATE OF DEATH Month NOV Day 24 Year 1959	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-1869
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JOHN W. PERKINSON		14. MOTHER'S MAIDEN NAME GEORGIANNA BURDETTE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr.		Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 years (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-9 , 19 57 , to 11-23 , 19 57 , that I last saw the deceased alive on 11-23 , 19 57 , and that death occurred at 3:21 P.M. from the causes and on the date stated above. Frank L. Smith Jr. ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 11/24/59			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 27, 1959	22c. NAME OF CEMETERY OR CREMATORY Lorraine	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		ADDRESS 1217 St. Paul St.	24a. REC'D BY REGISTRAR DATE NOV 27 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12200

Reg. Dist. No.

12231

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3yr10mths4days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 17, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Davis</u> Last <u>Bennett</u> <u>Cain</u>		4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>27</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Purnell Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Hester Anne Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Cerebral and generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell from chair to floor on 9-9-59 sustaining sub-capital frac. of left femur</u>	
20c. TIME OF INJURY Hour <u>8:00</u> a. m. <u>PM</u> Month, Day, Year <u>9-9 19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) (County) (State) <u>Catonsville 28, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Meth. Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Fountain Green, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Kieffer</u>		ADDRESS <u>17 1/2</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

12232

Reg. Dist. No. 32

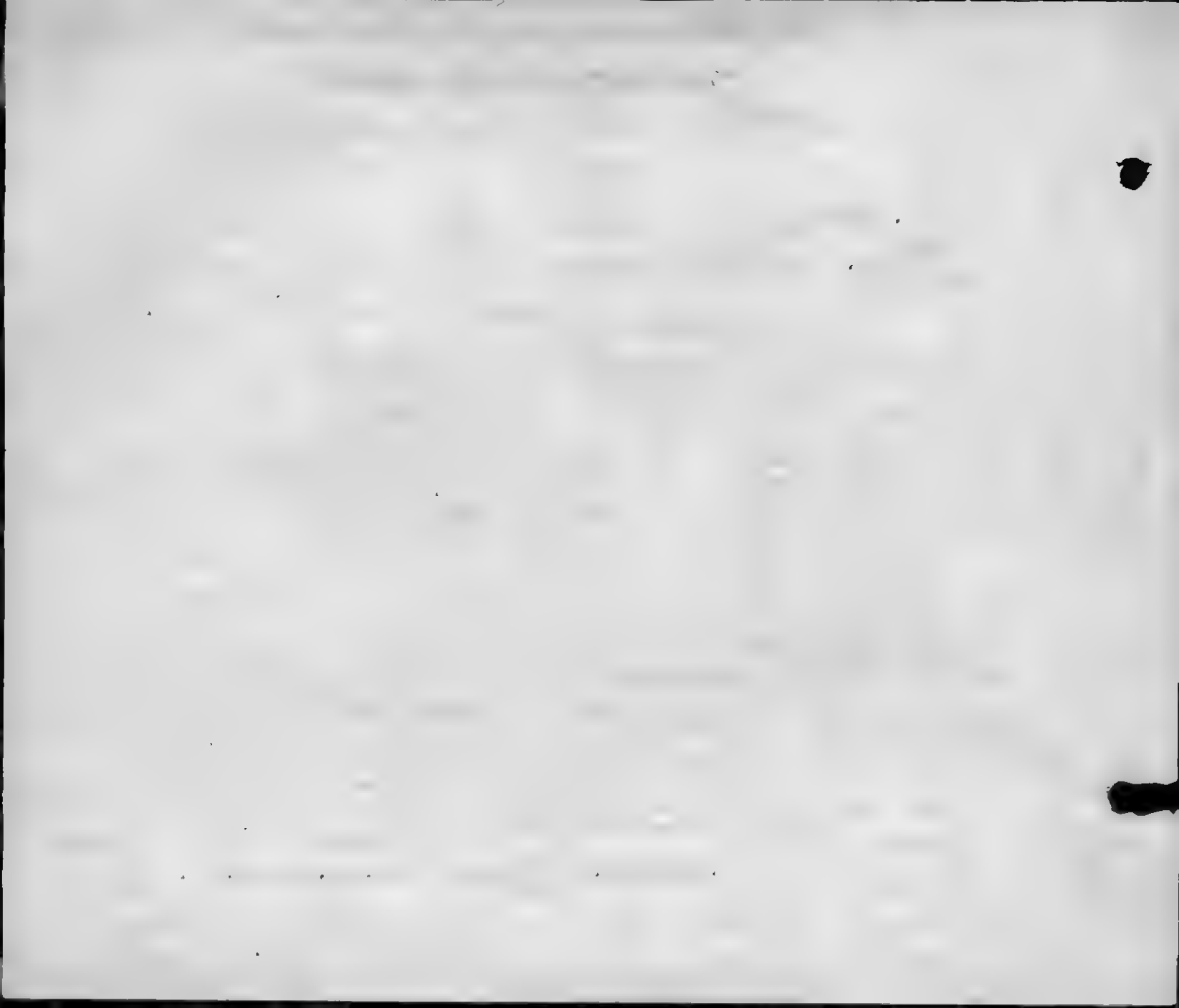
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt. Wilson</u>		<u>104 days</u>		OR TOWN <u>Bee Air</u>		<u>104</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>State Armory</u>			
3. NAME OF DECEASED (Type or Print) <u>John Henry Campbell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 19 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>S</u>	8. DATE OF BIRTH <u>11-25-1900</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Armory</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Campbell Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Asher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>				16. SOCIAL SECURITY NO. <u>215-18-5358</u>		17. INFORMANT'S ADDRESS <u>Hospital Records</u>	
				<u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u>						<u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-7</u> 19 <u>58</u> , to <u>11-19</u> 19 <u>59</u> , that I last saw the deceased alive on <u>11-19</u> 19 <u>59</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/23/59</u>		NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>		LOCATION (City, town, or county) (State) <u>Hickory, Harford, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Joseph J. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Wilson</u>		ADDRESS	
DATE <u>NOV 24 '59</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this health certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12233

CERTIFICATE OF DEATH

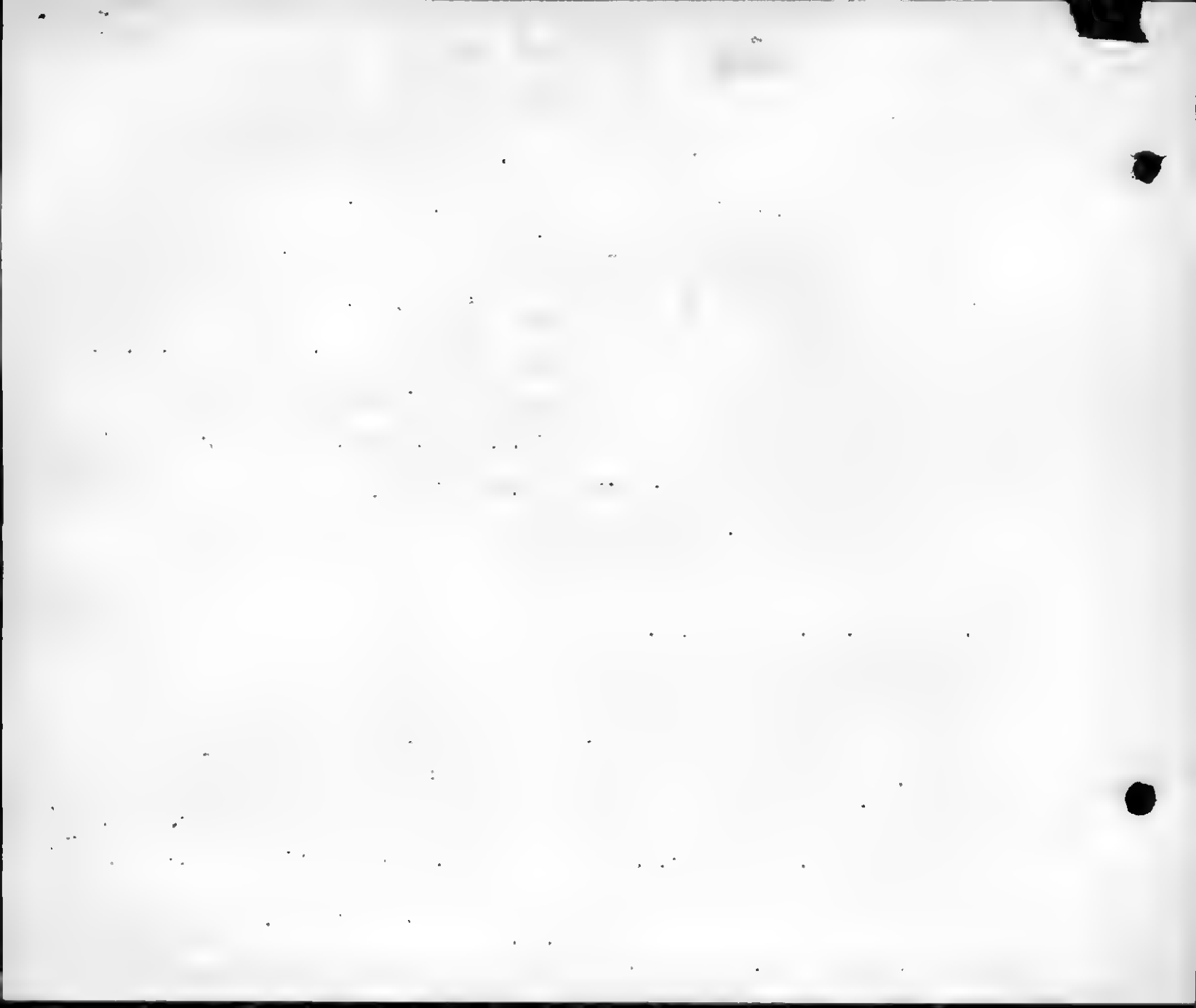
Reg. Dist. No.

12202

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 15 Hrs. 20 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 050 Veterans Administration Hospital		d. STREET ADDRESS 1716 N. Broadway Street	
3. NAME OF DECEASED (Type or print) (Served as First WILLIE Middle --- Last CARROLL) WILLIAM CARROLL		4. DATE OF DEATH Month November Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1896
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months 6 Days 3 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Fayetteville, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joe Carroll		14. MOTHER'S MAIDEN NAME Mary MN: Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-12-4046	
17. INFORMANT Clin. Rec., VAH, Balto. 18, Md., Ft. Howard Division		Address Clin. Rec., VAH, Balto. 18, Md., Ft. Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, RIGHT LOWER LOBE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PORTAL CIRRHOSIS (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 Day Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Ascites. 2. Dehydration.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 3:10	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 8, 1959 at 3:10 Pm toll/8/59 and that death occurred at 6:30AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold R. Johnson		ADDRESS (Street, city or town, state) VAH, FT. HOWARD DIVISION BALTO. 18, MD.	
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.		DATE SIGNED 11/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-12-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Lewis Mortuary 1639 N. Broadway		24a. REC'D BY REGISTRAR NOV 10 1959	24b. REGISTRAR'S SIGNATURE Arthur P. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained at hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12234

CERTIFICATE OF DEATH

Reg. Dist. No. 12203

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth 28 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Ellen Last Caviness		4. DATE OF DEATH Month Nov. Day 21 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 69 yrs.
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure (grade IV) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial degeneration and Hypertrophy (c) Arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH months years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 22, 1959 to Nov. 21, 1959 , that I last saw the deceased alive on Nov. 20, 1959 and that death occurred at 2:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-21-59			
ACTUAL SIGNATURE [Signature] M.D.			
PHYSICIAN'S NAME (Type) ARISTIDES M. SIMOPOULOS Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS	22d. LOCATION (City, town, or county) (State) BALTIMORE, MD
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC		ADDRESS 715 LIGHT ST	24a. REC'D BY REGISTRAR DATE NOV 24 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTO. -30, MD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12204

12206

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hailthrope		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hailthrope	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4300 Ridge Avenue		e. STREET ADDRESS 4300 Ridge Avenue	
3. NAME OF DECEASED (Type or print) First John Middle Chisley Last Chisley		4. DATE OF DEATH Month November Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875 6/22
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months 10 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Pa. Railroad	
11. BIRTHPLACE (State or foreign country) Arundel County, Md.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME George Washington Chisley		14. MOTHER'S MAIDEN NAME Catherine (Maiden Name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) (Unknown)		16. SOCIAL SECURITY NO. Agnes Chisley	
17. INFORMANT Agnes Chisley		Address 4300 Ridge Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Proximal disease & decomposition (c) General atherosclerosis Probable intestinal obstruction & dehydration		INTERVAL BETWEEN ONSET AND DEATH 6 or 8 months + years 46 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 8 to Nov 10 , 19 59 , that I last saw the deceased alive on Nov 9 , 19 59 , and that death occurred at 9:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE FREDERICK V. BEITLER		ADDRESS (Street, city or town, state) 1112-59 DATE SIGNED	
PHYSICIAN'S NAME (Type) FREDERICK V. BEITLER		M.D. 1014 Francis Ave. Balto 27 Md	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF 11/14/1959	
22c. NAME OF CEMETERY OR CREMATORY Arundel Memorial		22d. LOCATION (City, town, or county) (State) Arundel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams		ADDRESS 322 N. Schroeder St.	
24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kneass	



FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12205

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 603 Marwood Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 603 Marwood Road	
3. NAME OF DECEASED (Type or print) HELEN RICHTER CLAGETT		4. DATE OF DEATH Month November Day 23 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 9, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9. AGE (In years last birthday) 57 yrs. 57 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY RICHTER		14. MOTHER'S MAIDEN NAME MATILDA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MR. THOMAS J. CLAGETT III		Address 603 MARWOOD ROAD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate Intoxication. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overdose of barbiturate 20c. TIME OF INJURY Month, Day, Year 11/23 19 59 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Towson (County) Baltimore (State) Md.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DATE SIGNED 11/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/25/59	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		22d. LOCATION (City, town, or country) CATONSVILLE MD.	
23. FUNERAL DIRECTOR John Burns Sons		ADDRESS TOWSON MARYLAND	
24a. REC'D BY REGISTRAR NOV 30 '59		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

1.9

x

60

11/10



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12237

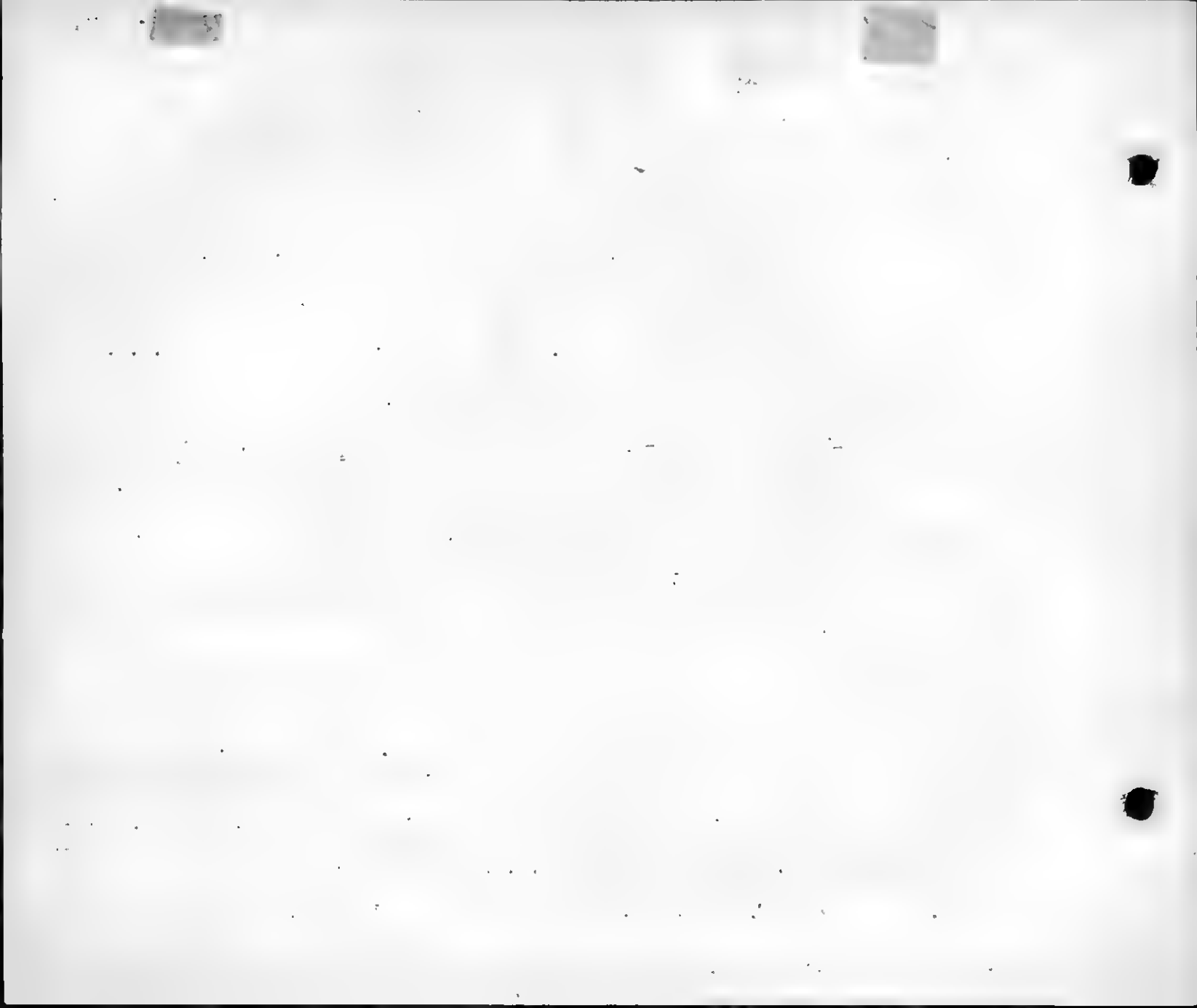
CERTIFICATE OF DEATH

Reg. Dist. No.

12207

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN lb 105 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY / c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 2114 ST LUKE'S LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HANNIBAL Middle C Last CLEMONS		4. DATE OF DEATH Month November Day 6 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 2 1893
9. AGE (In years lost birthday) yrs. 66		10. IF UNDER 1 YEAR Months 6 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTING CO.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS CLEMONS		14. MOTHER'S MAIDEN NAME JANE McKEEVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 579-01-2005	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 154X PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE DUE TO (c) CARCINOMA OF RECTUM		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from July 24 1959 to November 6 1959 and that death occurred at 10:40pm , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Baltimore Md-Ft Howard Div. DATE SIGNED 11-7-59			
ACTUAL SIGNATURE Lawrence D. Marcus M.D.		DATE SIGNED 11-7-59	
PHYSICIAN'S NAME (Type) Lawrence D. Marcus		M.D. VAH Baltimore Md-Ft Howard Division	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/10/59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE NOV 12 1959	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers Funeral Home ADDRESS 8728 Liberty Road Baltimore 7, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12238

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE 52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>174 WINTERS AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SANDY 'COE' COLE</u>		4. DATE OF DEATH Month Day Year <u>11 10 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER</u>	11. BIRTHPLACE (State or foreign country) <u>CATONSVILLE-MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWARD COE</u>	
14. MOTHER'S MAIDEN NAME <u>CHARITY HARRIS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>331X</u>		17. INFORMANT Address <u>JEANETTE C. WILLIAMS 174 WINTERS AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Rheumatoid Arthritis severe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 years</u> <u>2 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>16 Sept</u> , 19 <u>59</u> , to <u>10 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10 Nov</u> , 19 <u>59</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Williams</u>		ADDRESS (Street, city or town, state) <u>305A Winters Lane</u>	
PHYSICIAN'S NAME (Type) <u>Charles Robert Davidson</u>		DATE SIGNED <u>11/11/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/14/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>	22d. LOCATION (City, town, or county) (State) <u>Catonville md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall F. Hays</u>		24a. REC'D BY REGISTRAR <u>11/12/59</u>	
ADDRESS <u>638 N. Gilmor St</u>		24b. REGISTRAR'S SIGNATURE <u>(with 2 persons)</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12239

CERTIFICATE OF DEATH

12209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 570 Chalcot Square Baltimore Co. 21, Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21, Md.		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 570 Chalcot Square		d. STREET ADDRESS 570 Chalcot Square	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marie Virginia Coleman		4. DATE OF DEATH Month November Day 18 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Tyler		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Grace Morano		Address 570 Chalcot Sq. Essex 21, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Cardiovascular disease (c) disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1953, to Nov. 18, 1959, that I last saw the deceased alive on Nov. 10, 1959, and that death occurred at 7:35 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli M.D.		ADDRESS (Street, city or town, state) 108 S. Taylor Ave DATE SIGNED 11/18/59	
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D. Baltimore 21 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59	
22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. Christine Bruchowski 1407 Eastern Ave (21)		24a. REC'D BY REGISTRAR DATE NOV 20 '59	
24b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

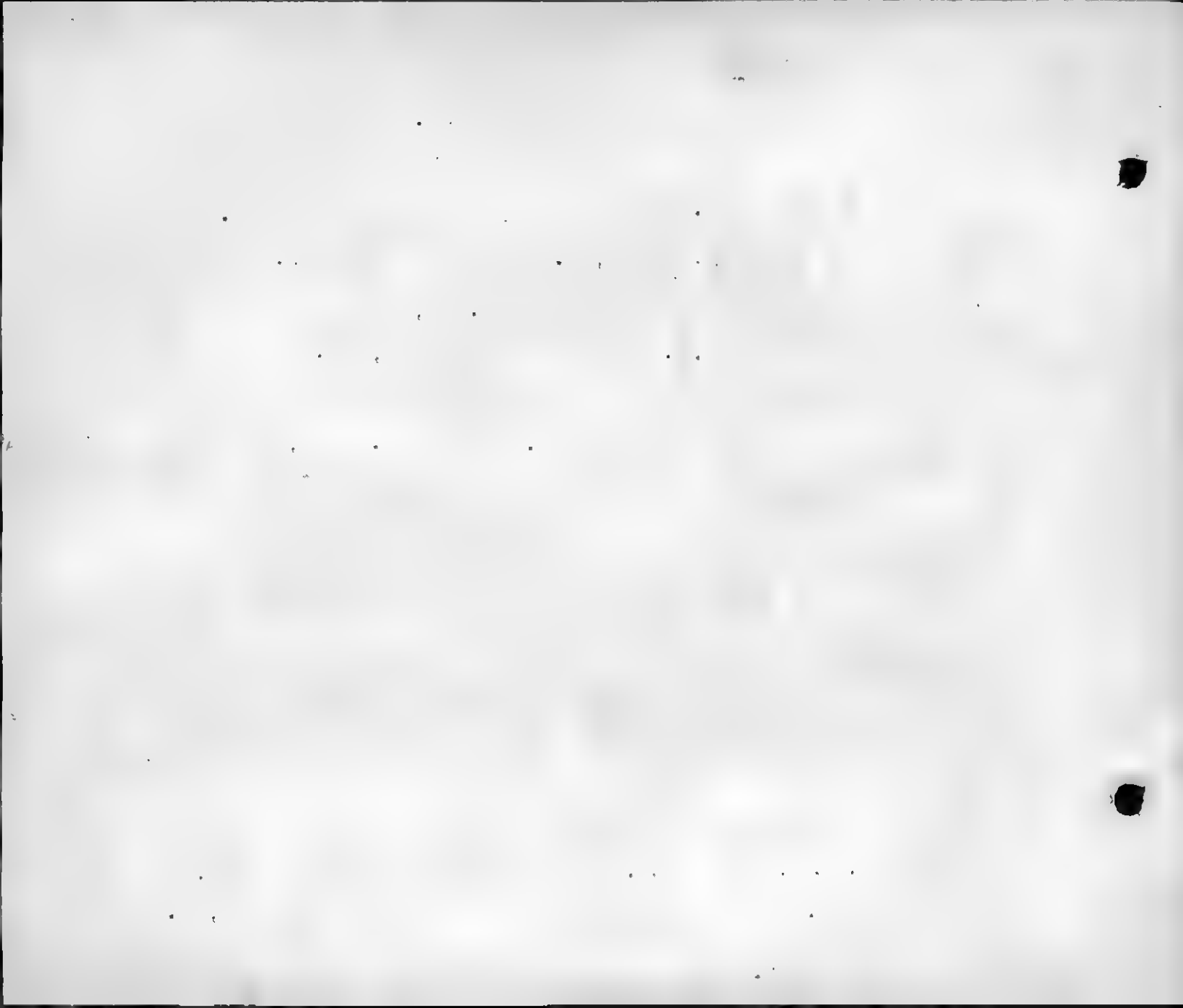
12240

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1932 Old Frederick Rd.		e. STREET ADDRESS 1932 Old Frederick Rd.	
3. NAME OF DECEASED (Type or print) Joseph P. Cooke, Sr.		4. DATE OF DEATH Nov. 22/59 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1916
9. AGE (In years last birthday) 43 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Geo. W. Cooke & Associates	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cooke		14. MOTHER'S MAIDEN NAME Clementine Stickmeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 216 10 3403	
17. INFORMANT Mrs. Phyllis A. Cooke		Address 1932 Old Frederick Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov. 22, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors		24a. REC'D BY REGISTRAR DATE NOV 24 '59	
ADDRESS 4101 S. Mondson Ave.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kieffer</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12241

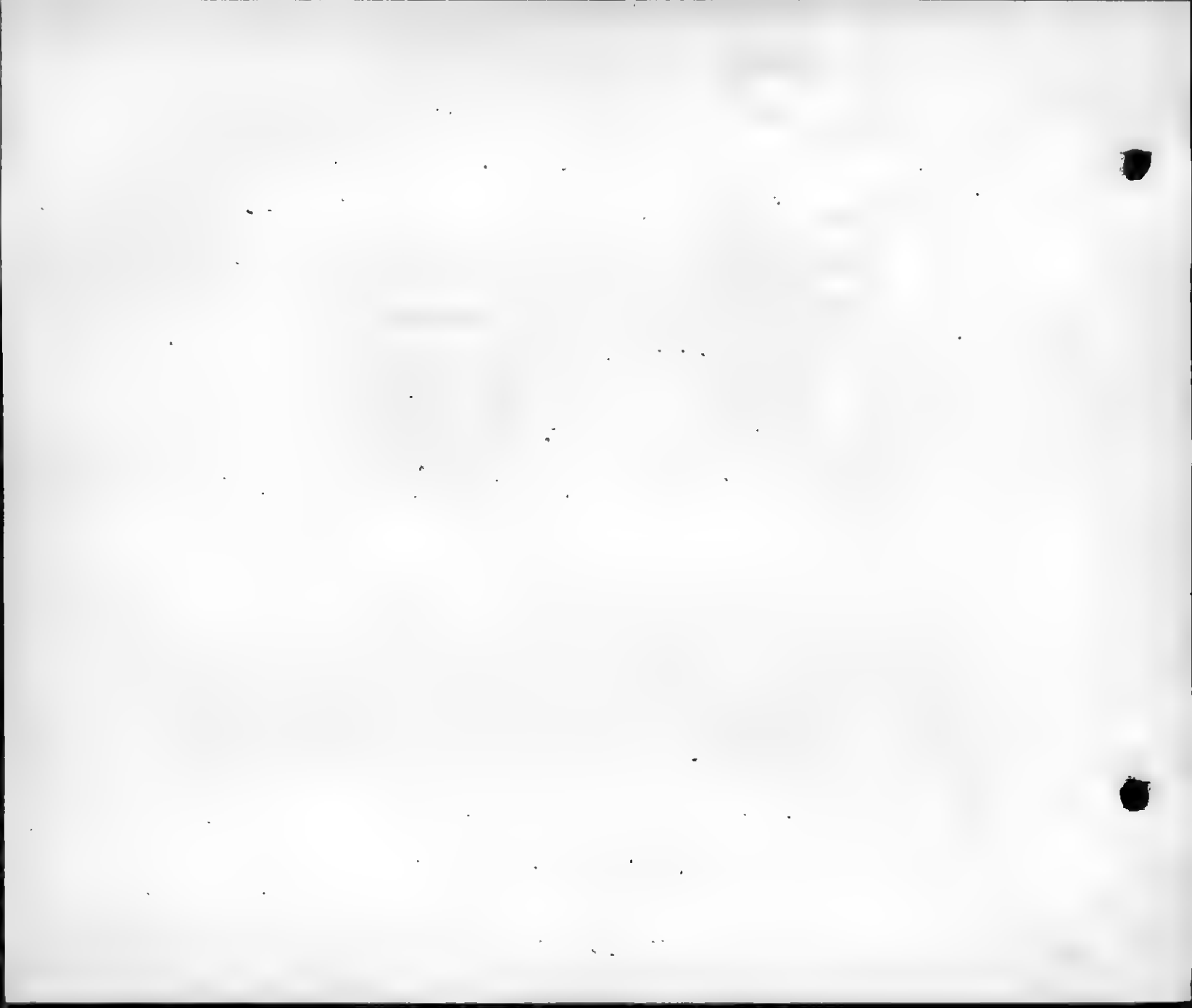
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. LENGTH OF STAY IN 1b <u>63 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Baltimore 27.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Nursing Home</u>				d. STREET ADDRESS <u>12306 Small Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donna</u> Middle <u>M.</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1959</u>					
5 SEX <u>M</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1877</u>	9. AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Druggist</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Hyke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>Informant</u>		Address <u>Living Rehearsal - same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>11/11/59</u> , 19 <u>59</u> that I last saw the deceased alive on <u>11/11/59</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Reiter</u>		M.D.		ADDRESS (Street, city or town, state) <u>3408 W. Anderson Ave Baltimore 16, Md</u>		DATE SIGNED <u>11/19/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Reiter, M.D.</u>		<u>Baltimore 16, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>				ADDRESS <u>2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>NOV 23 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or attending physician's office.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

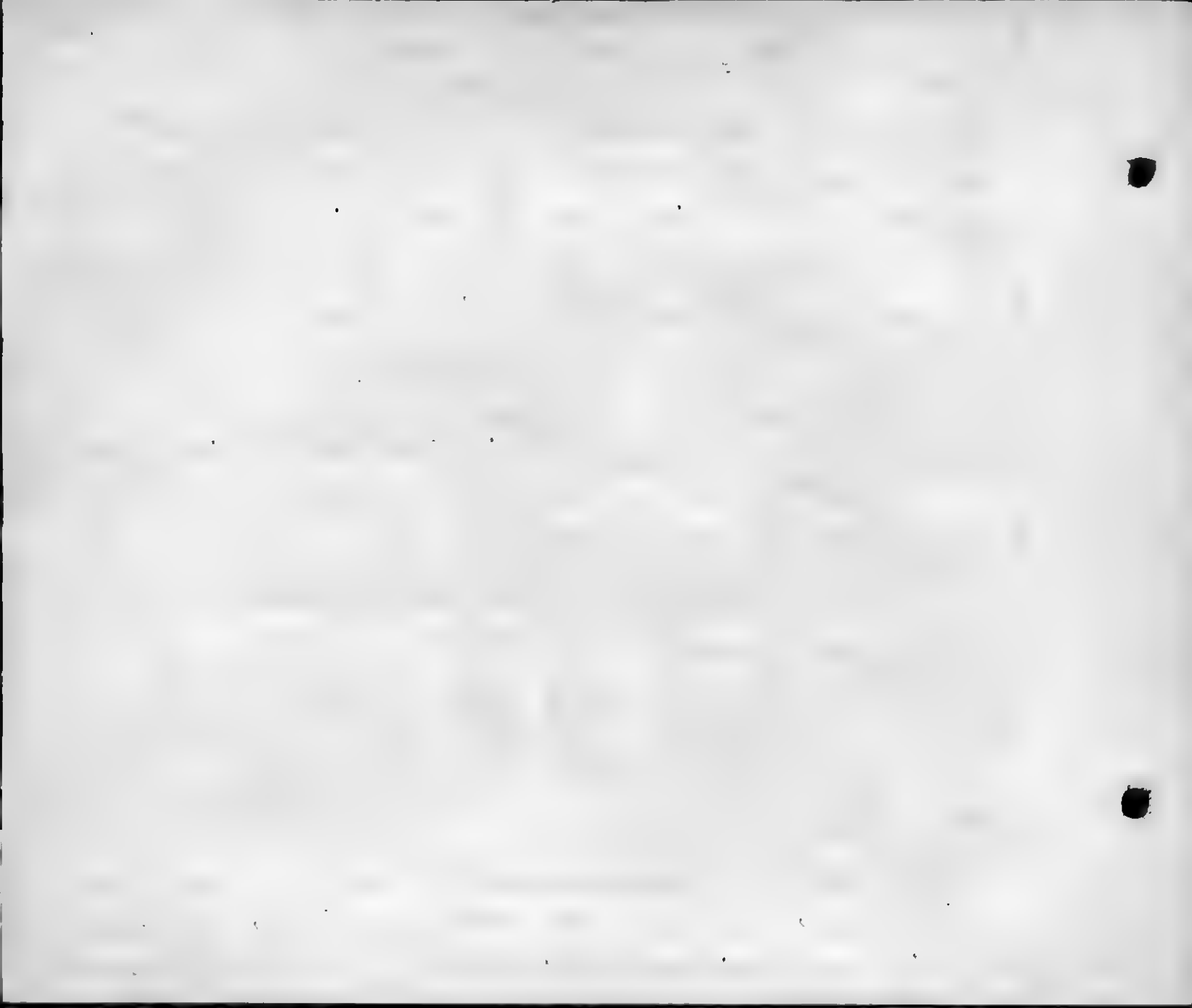


CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>		c. LENGTH OF STAY IN 1b <i>7/1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1309 Taylor Ave.</i>		d. STREET ADDRESS <i>1309 Taylor Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Terence</i> First <i>Cox</i> Middle <i>Cox</i> Last		4. DATE OF DEATH <i>November 5</i> Month <i>5</i> Day <i>1959</i> Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 9, 1883</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State of Md. Pen.</i>	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Cox</i>		14. MOTHER'S MAIDEN NAME <i>Sarah McGuire</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>John F. Cox</i> Address <i>1309 Taylor Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration</i> <i>199.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intestinal obstruction</i> DUE TO (c) <i>Carcinoma within abdomen - original site unknown?</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>2 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/14</i> , 19 <i>54</i> , to <i>11/5</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11/4</i> , 19 <i>59</i> , and that death occurred at <i>4:30</i> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George H. Beck</i> M.D.		ADDRESS (Street, city or town, state) <i>6012 Harford Road Baltimore, Md.</i> DATE SIGNED <i>11/6/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 9, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i> ADDRESS <i>3000 E. Baltimore St.</i>		24a. REC'D BY REGISTRAR <i>NOV 10 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Friend</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12243

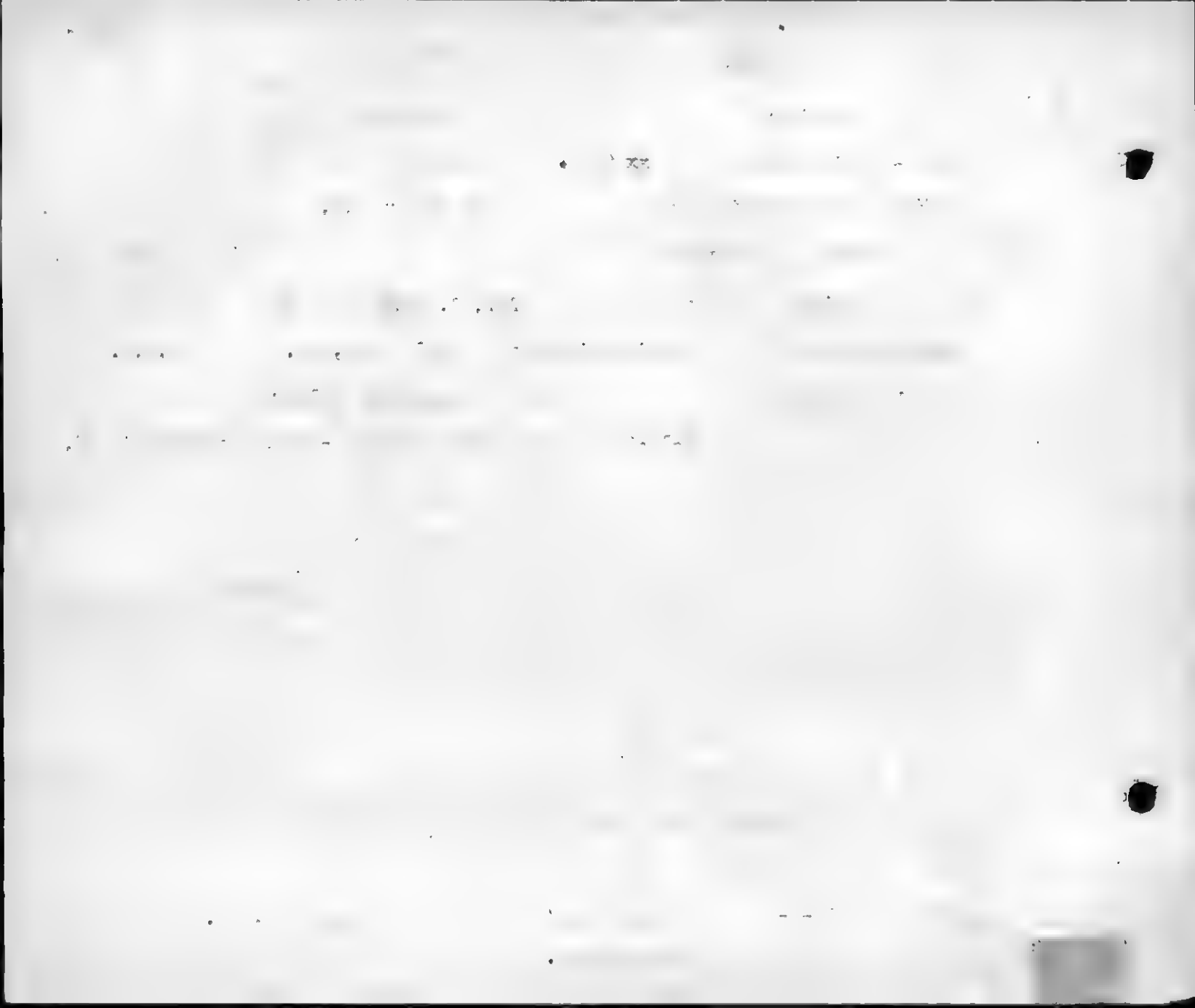
CERTIFICATE OF DEATH

12213

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Middle River c. LENGTH OF STAY IN 1b 3 5 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Convelescent Home		2. USUAL RESIDENCE (Where deceased lived If instituton Residence before admission) a. STATE Maryland b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1826 Walnut Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) George J. Cumberland		4. DATE OF DEATH Month 11 Day 29 Year 19 59	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 1, 1891
9. AGE (In years last birthday) 68 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pattern Maker	
10b. KIND OF BUSINESS OR INDUSTRY Martins Aircraft		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Henry Cumberland	
14 MOTHER'S MAIDEN NAME Margaret Kellner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO 214-16-9133		INFORMANT Address Elizabeth Stoecker - 8053 Philadelphia Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 422.1 DUE TO Arteriosclerotic Cardio Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Disease 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 , 19 59 , to 11-29 , 19 59 , that I last saw the deceased alive on 11-29 , 19 59 , and that death occurred at 11 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore Md. DATE SIGNED			
ACTUAL SIGNATURE W. B. Cunningham M.D.			
PHYSICIAN'S NAME (Type) W. B. Cunningham			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-2-59	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Thelma E. Couch		ADDRESS 1211 Chesaco Ave.	
24a. REC'D BY REGISTRAR DATE DEC 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



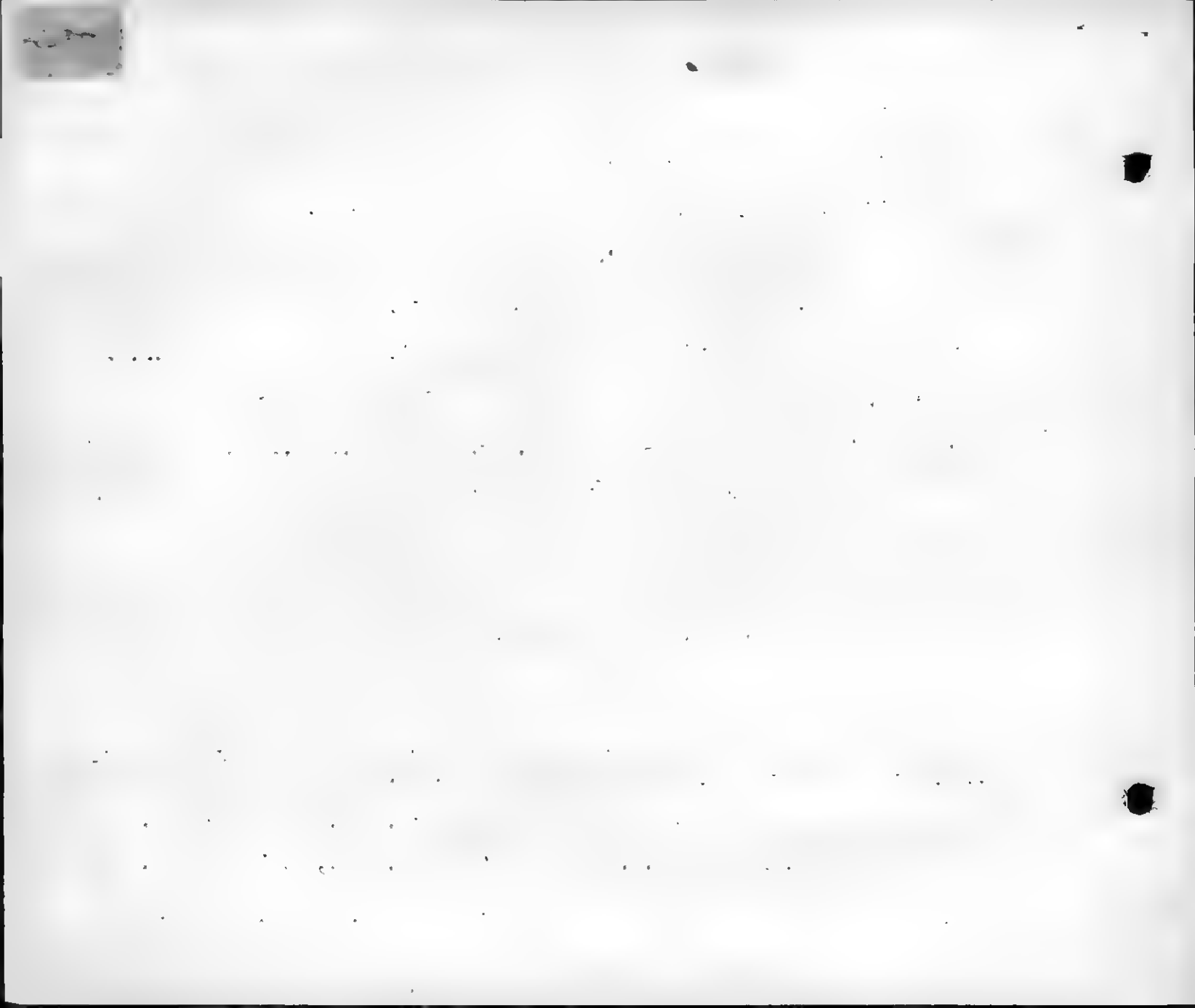
12244 CERTIFICATE OF DEATH

Reg. Dist. No.

12214

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Howard				c. LENGTH OF STAY IN 1b 64 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 5725 First Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FREDERICK Middle J. Last DADD				4. DATE OF DEATH Month November Day 28 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1889	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Davenport, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainman				10b. KIND OF BUSINESS OR INDUSTRY Railroad			
13. FATHER'S NAME James H. Dadd				14. MOTHER'S MAIDEN NAME Elizabeth Saunders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO 705-09-6704			
17. INFORMANT Clin. Rec., VAH Balto., Md., Ft. Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA & EDEMA OF LUNGS							
491X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
CEREBRAL ARTERIOSCLEROSIS; DIABETES MELLITUS, MILD							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from September 25, 1959 , to November 28, 1959 , and that death occurred at 4:55 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state; DATE SIGNED							
ACTUAL SIGNATURE Harold R. Johnson M.D. VAH Balto., Md., Ft. Howard Div. 11/28/59				DATE SIGNED			
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D. VAH Balto., Md., Ft. Howard Div. 11/28/59				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/59		22c. NAME OF CEMETERY OR CREMATORY London Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose Inc. 1328 Sulphur Spring Rd				24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

AMBROSE FUNERAL HOME, 1328 SULPHUR SPRING RD., BALTO. 27, MD.



may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

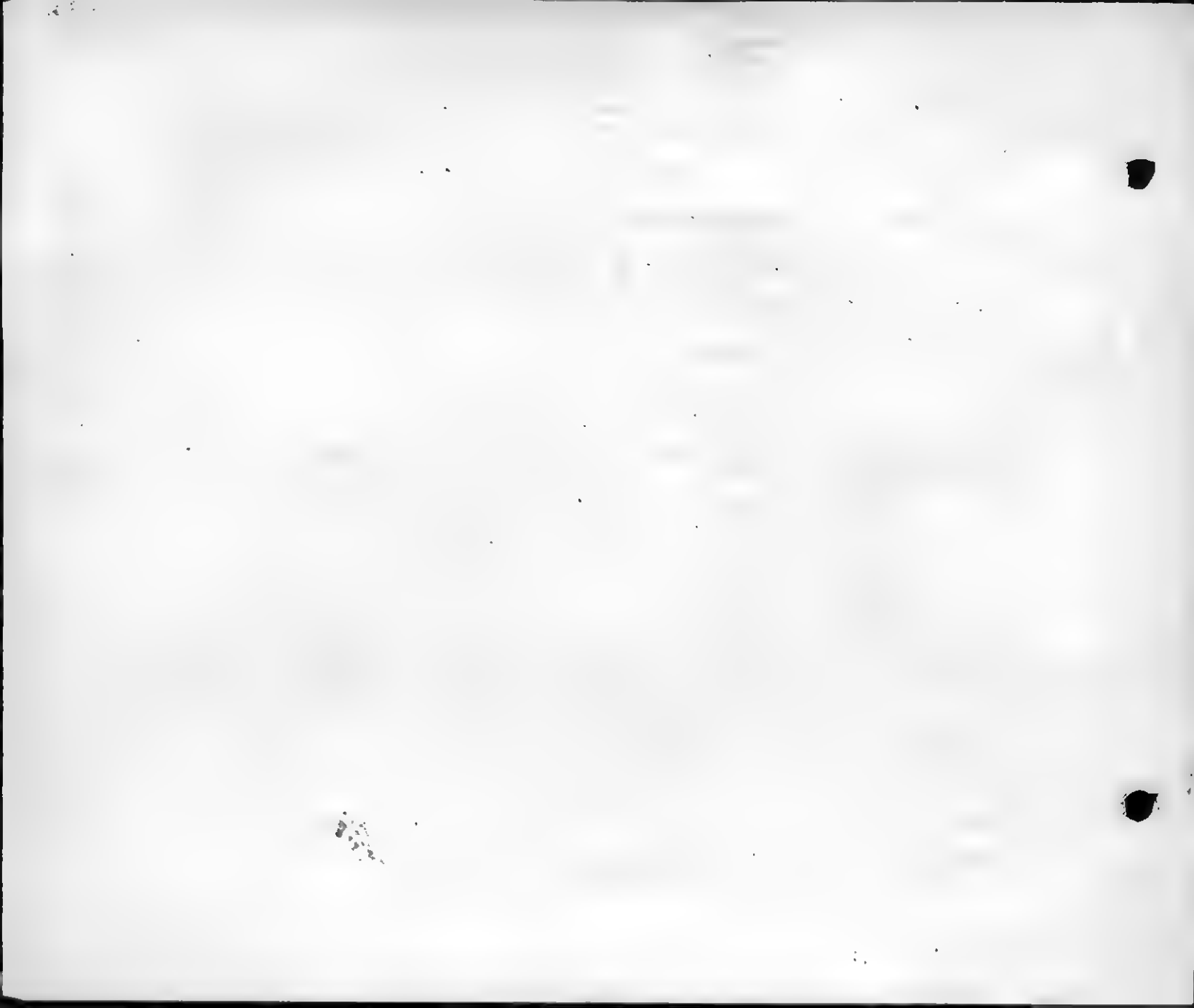
12245

CERTIFICATE OF DEATH

12215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calonsville</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Haven Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William E. Dailey</i> First Middle Last		4. DATE OF DEATH <i>Nov. 16</i> Month Day Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/12/72</i>
9. AGE (In years last birthday) <i>86</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self emp.</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Dailey</i>		14. MOTHER'S MAIDEN NAME <i>Riley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Nellie V. Dailey, Sparrow, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>ARTERIO SCLEROSIS CORONARY VASCULAR DISEASE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CORONARY THROMBOSIS</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>9/1</i> , 19 <i>59</i> , to <i>11/16</i> , 19 <i>59</i> ; that I last saw the deceased alive on <i>11/16</i> , 19 <i>59</i> , and that death occurred at <i>10:20</i> M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>John H. Shaw, M.D.</i> ADDRESS (Street, city or town, state) <i>5800 EDWARDS RD BALTO, MD</i>		DATE SIGNED <i>11/17/59</i>	
PHYSICIAN'S NAME (Type) <i>John H. Shaw, M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>11-19-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	
22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Stab + Son</i> ADDRESS <i>28</i>	
24a. REC'D BY REGISTRAR <i>NOV 20 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Harris</i>	



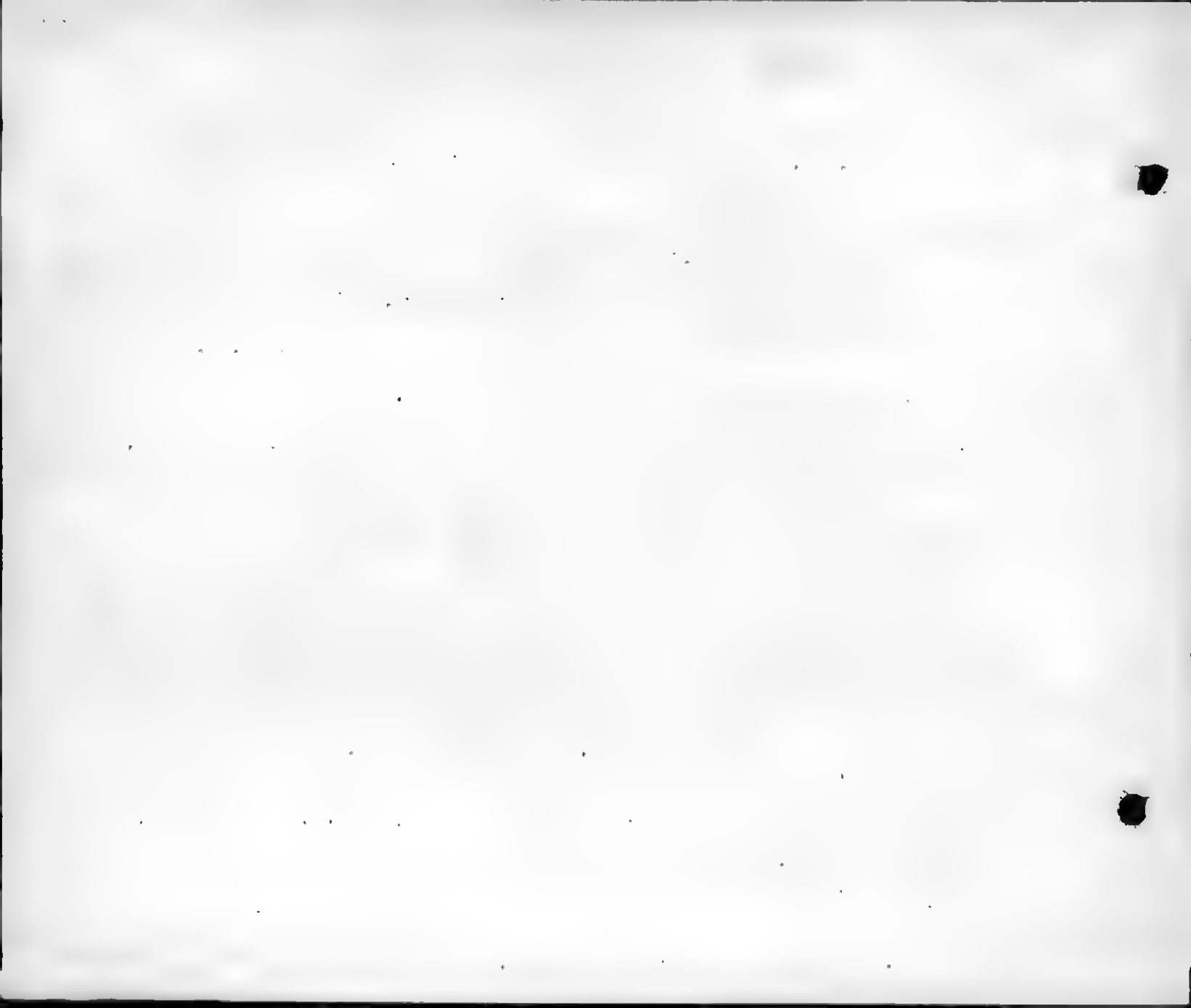
12245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Edward</u> Last <u>Daughton</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 27, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Daughton</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie M. Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-16-6908</u>	
17. INFORMANT <u>Elizabeth McCall Daughton, Sparks, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardio vascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>46</u> , to <u>Nov.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>31 October</u> , 19 <u>59</u> , and that death occurred at <u>11:05 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Walter T. Kees</u> M. D. <u>Cockeysville, Md.</u> <u>November 1, 1959</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stevenson Church Cemetery Sparks, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson</u>		ADDRESS <u>916 Pennsylvania Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12247

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1 mth 4dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1215 N. Augusta Avenue			
3. NAME OF DECEASED (Type or print) First Helen Middle D. Last Dauids				4. DATE OF DEATH Month November Day 17 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1897 April 22, 1901	9. AGE (In years and birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telephone operator				10b. KIND OF BUSINESS OR INDUSTRY U.S. Steamship Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Dailey				14. MOTHER'S MAIDEN NAME Mary Shorten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated gastric ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 16, 1959 , to Nov. 17, 1959 , that I last saw the deceased alive on Nov. 17, 1959 , and that death occurred at 11:55 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 11-18-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard RX				ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE NOV 20 1959	
				24b. REGISTRAR'S SIGNATURE Charles S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO
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FOR STATE
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

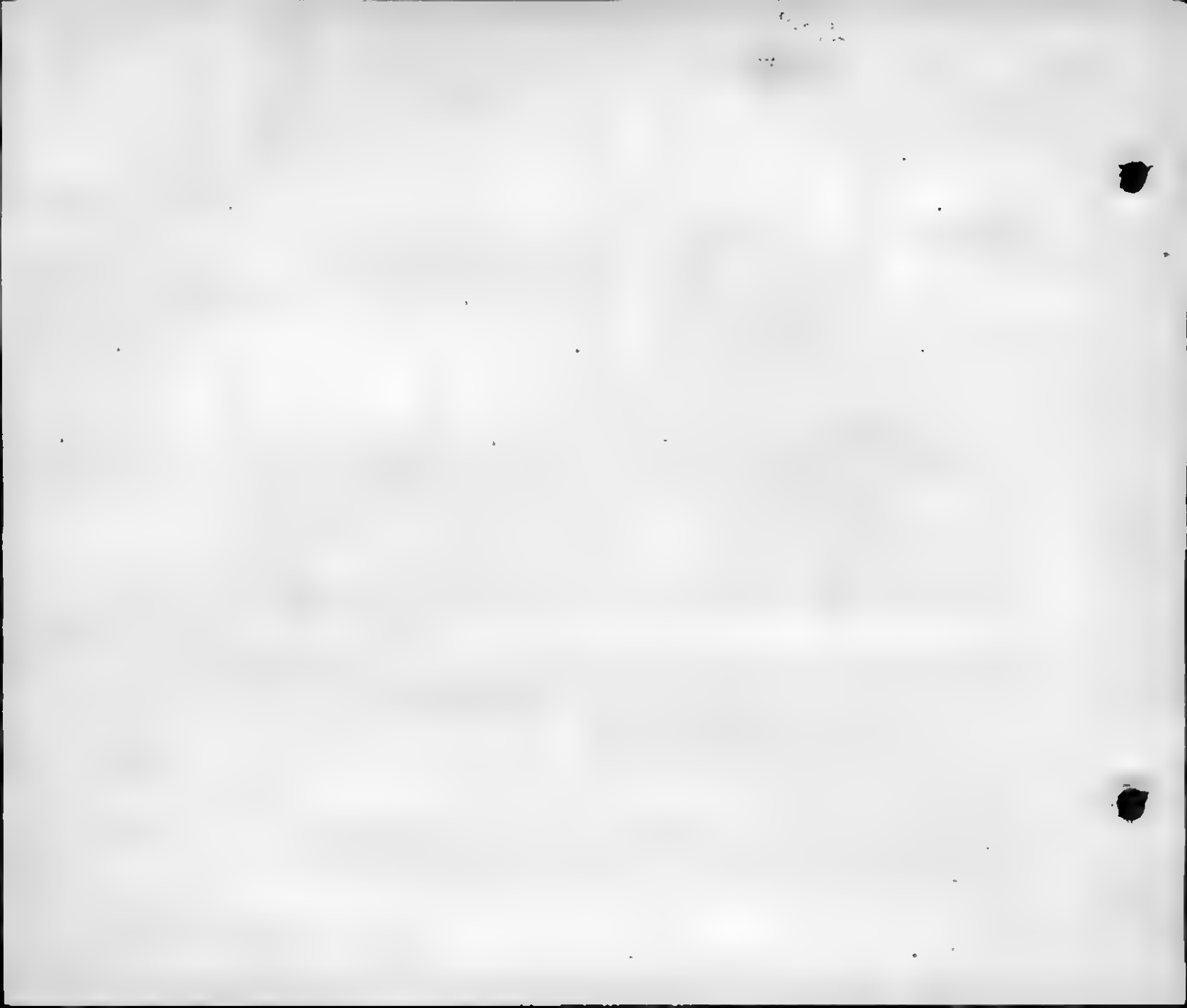
12218

Reg. Dist. No.

12196

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 2076 Larkhall Road		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 2076 Larkhall Rd. e. IS RESIDENCE ON XXXX YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Franklin Last Davis		4. DATE OF DEATH Month Nov. Day 6, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1923
9. AGE (In years last birthday) 35 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Clerk	11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Mims Davis	
14. MOTHER'S MAIDEN NAME Lexie Rivers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Navy, WWII	
16. SOCIAL SECURITY NO. 251-26-2994		17. INFORMANT Address Mrs. Azilee Davis 2076 Larkhall Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STRANGULATION = (HANGING) 974x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Hung Self from Straway RAILING	
20c. TIME OF INJURY Month, Day, Year 8:30 p.m. 11-6-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. CITY OR TOWN Dundalk - Baltimore	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10-59	
22c. NAME OF CEMETERY OR CREMATORY Chesterfield, South Carolina		22d. LOCATION (City, town, or county) (State) South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22, Maryland		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12248

CERTIFICATE OF DEATH

Reg. Dist. No. 12219

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Baltimore County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maryland Masonic Homes</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Anna</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 11, 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME (unknown) Weiss				14. MOTHER'S MAIDEN NAME Emma Wimmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>G. M. Bosley - Masonic Home - Cockeysville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u>1959</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Oct. 25, 1956</u> , to <u>Nov. 18, 1959</u> , that I last saw the deceased alive on <u>Nov. 18, 1959</u> , and that death occurred at <u>4:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Keas</u>				ADDRESS (Street, city or town, state) <u>Cockeysville, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. Keas</u>				DATE SIGNED <u>Nov. 18, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 20 1959



12207

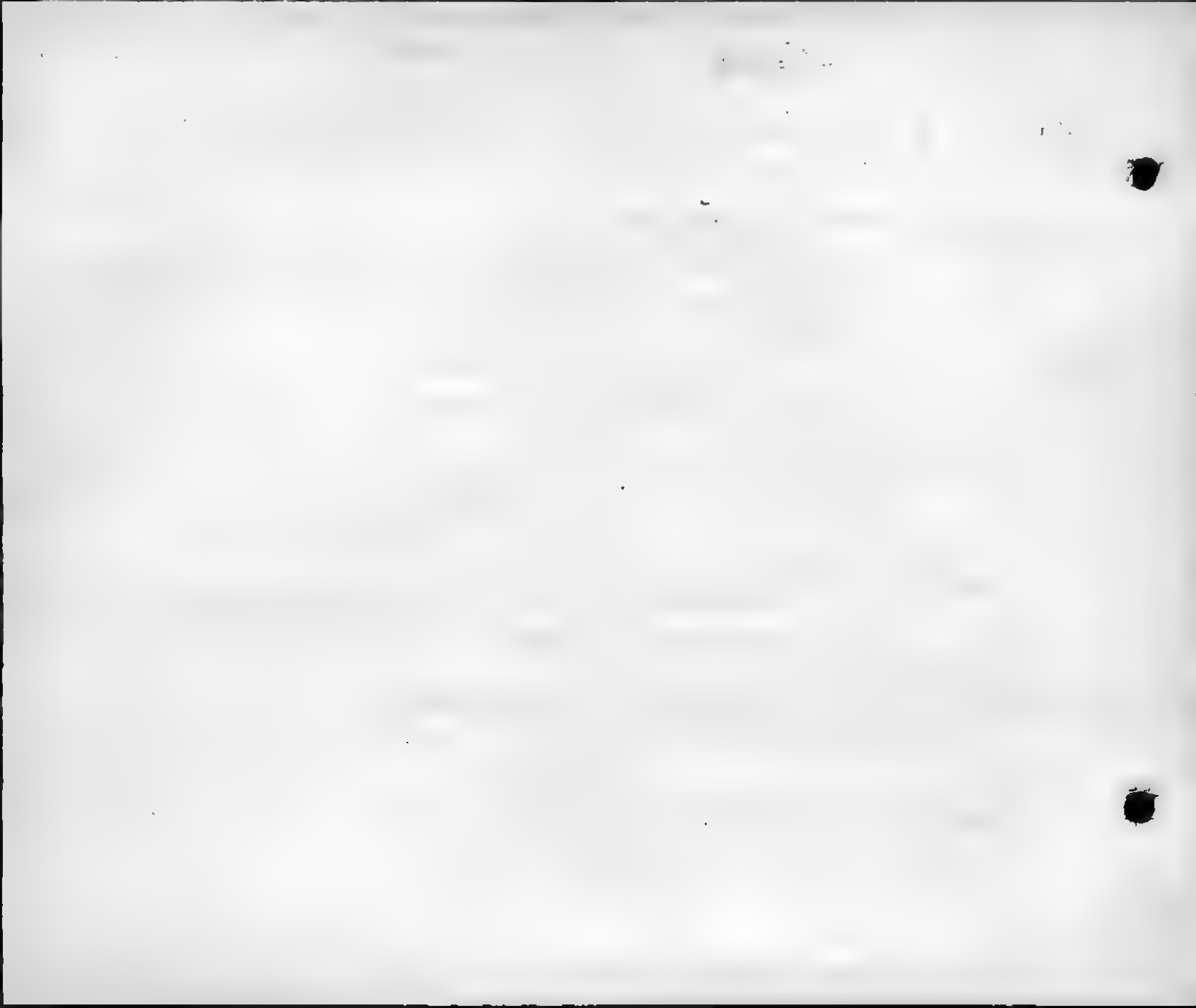
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5654 Carville Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian M. Dawson</u>		4. DATE OF DEATH Month Day Year <u>November 24 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Biggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address <u>Florence E. Dawson 5654 Carville Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 41 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Rheumatic Valvular Heart Disease Undet</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Secondary.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 10</u> , 19 <u>58</u> , to <u>Nov 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>59</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Bradley A. Daugherty</u> M.D.		1264 Francis Ave. Balto 27 Md 11-25-59	
PHYSICIAN'S NAME (Type) <u>Bradley A. Daugherty</u>		1264 Francis Ave (27)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ambrose, Inc. 1328 Sulphur Spring Rd</u>		24a. REC'D BY REGISTRAR DATE NOV 27 '59	24b. REGISTRAR'S SIGNATURE <u>O. H. S. Hester</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12221

12249

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>		c. LENGTH OF STAY IN 1b <u>Rural</u> <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Fidelia De Katow</u>		4. DATE OF DEATH Month Day Year <u>November 25 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS.</u>	11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Al. 'onse De Katow</u>	
14. MOTHER'S MAIDEN NAME <u>Hornie ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Sister M. Peter Feiler</u> Address <u>Noted 01/20, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>153.8</u> DUE TO <u>Cancer of bowels</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of bowels</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>54</u> , to <u>November</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>November 25</u> , 19 <u>59</u> , and that death occurred at <u>7:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7, 01 Horic Road, Towson, Md.</u> DATE SIGNED <u>11/27/59</u>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Zeiler</u> ADDRESS <u>9015 CUNKLING ST. BALTO. 24, MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12250

CERTIFICATE OF DEATH

Reg. Dist. No.

12222

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 2 1/2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA HELEN DIVEN				4. DATE OF DEATH Month Day Year NOV 12 1957			
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1883	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME GILBERT J. BUNN			
14. MOTHER'S MAIDEN NAME KATHERINE LUTZ				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT Address Frank L. Smith Jr. - Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/15 , 19 57 , to 11/11 , 19 57 , that I last saw the deceased alive on 11/11 , 19 57 , and that death occurred at 4:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 11/12/59 ACTUAL SIGNATURE Robert J. Kues M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-14-59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE NOV 13 59		24b. REGISTRAR'S SIGNATURE Conrad L. Kues	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12251

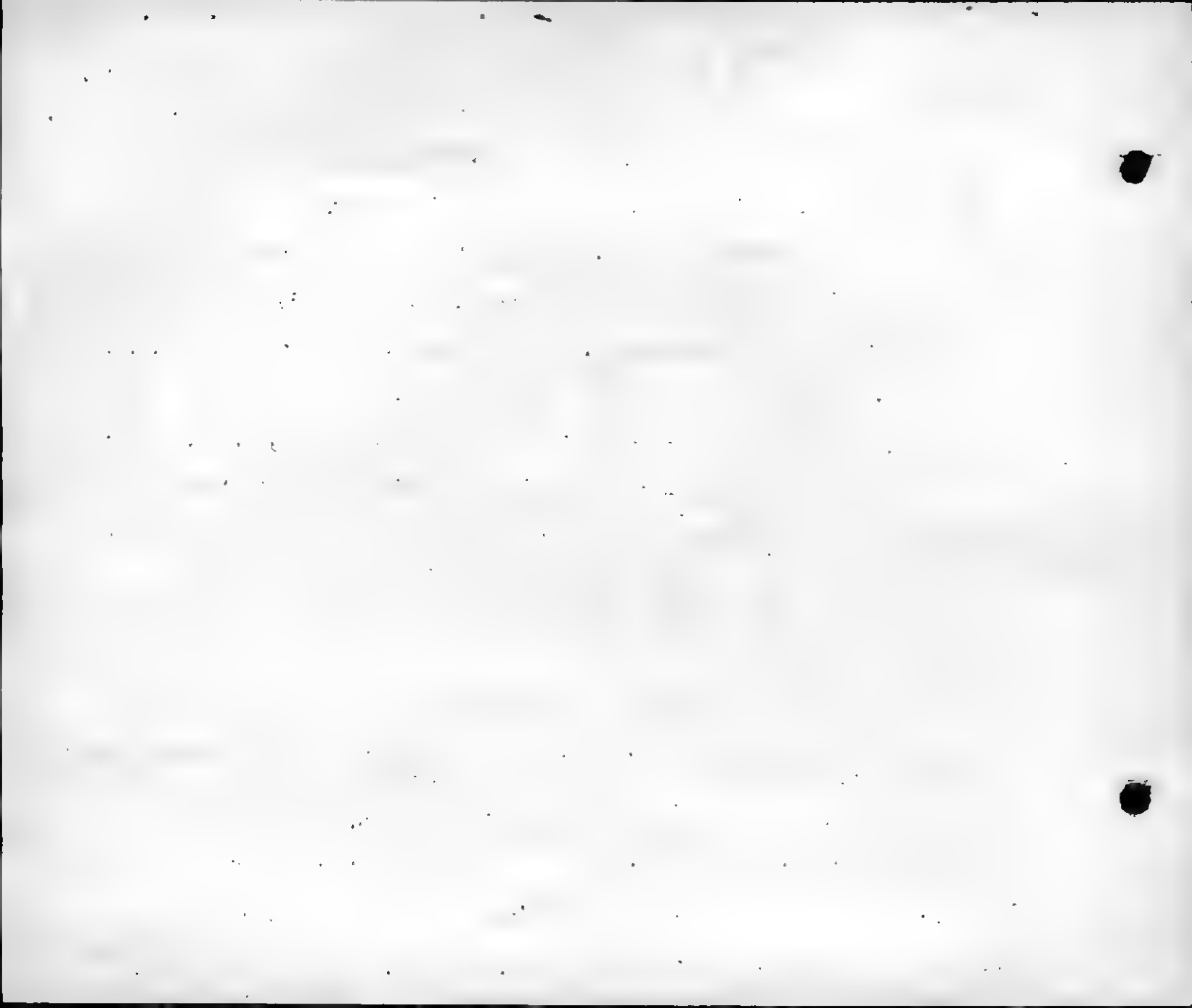
CERTIFICATE OF DEATH

12223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 147 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 44 "B" Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARROLL Middle S. Last DIVEN		4. DATE OF DEATH Month November Day 6 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 11, 1925
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.	11. IF UNDER 24 HRS Months 33 Days 33 Hours 33 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxicab Co.	11. BIRTHPLACE (State or foreign country) Laurel, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George E. Diven	
14. MOTHER'S MAIDEN NAME Mary Geis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II	
16. SOCIAL SECURITY NO 218-12-7769		17. INFORMANT Address Clin. Records, VAH, Balto 18, Md. Ft. Howard Div	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HODGKINS DISEASE WITH INVOLVEMENT OF LYMPH NODES SPLEEN, LIVER AND LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) JAUNDICE DUE TO COMPRESSION OF COMMON BILE DUCT (c) CACHEXIA MODERATE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CACHEXIA MODERATE	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from June 12, 1959 to November 6, 1959 , and that death occurred at 2:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Caridad E. Gonzalez		ADDRESS (Street, city or town, state) VAH BALTO MD. FT HOWARD DIVISION	
PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M. D.		DATE SIGNED 11/6/59	
22a. BURIAL CREMATION REMOVAL (Specify) Removal		22b. DATE THEREOF 11-6-59	
22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Funeral Home		24a. REC'D BY REGISTRAR NOV 10 '59	
ADDRESS 6009 Harford Rd. Balto. Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Delivered by Hearse to: DENITT DONALDSON FUNERAL HOME, LAUREL, MD.



12252

CERTIFICATE OF DEATH

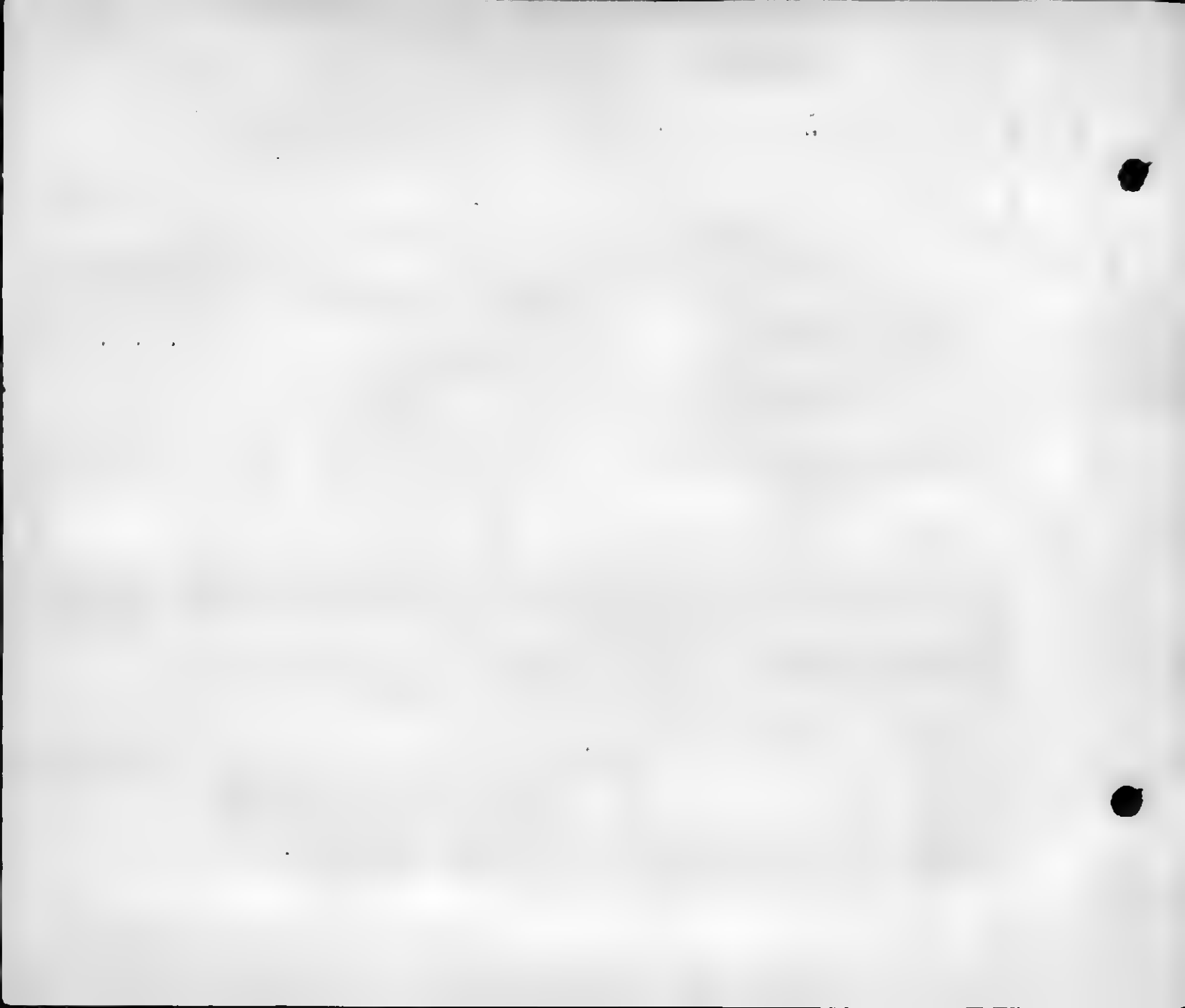
12224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Mary</u> Last <u>Dolby</u>		4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Sara Chaney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u>SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERAL DEBILITY</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 8, 1959</u> , to <u>NOV. 23, 1959</u> , that I last saw the deceased alive on <u>NOV. 23, 1959</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>P. K. YIP</u>			
ACTUAL SIGNATURE <u>P. K. YIP</u>		M D <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>P. K. YIP</u>		Catonsville 2, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Southland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS</u>		ADDRESS <u>Bros. 1661-Good Hope Rd S.E.</u>	
24a. RECEIVED BY REGISTRAR <u>NOV 25 59</u>		24b. REGISTRAR'S SIGNATURE <u>Edward A. Thayer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

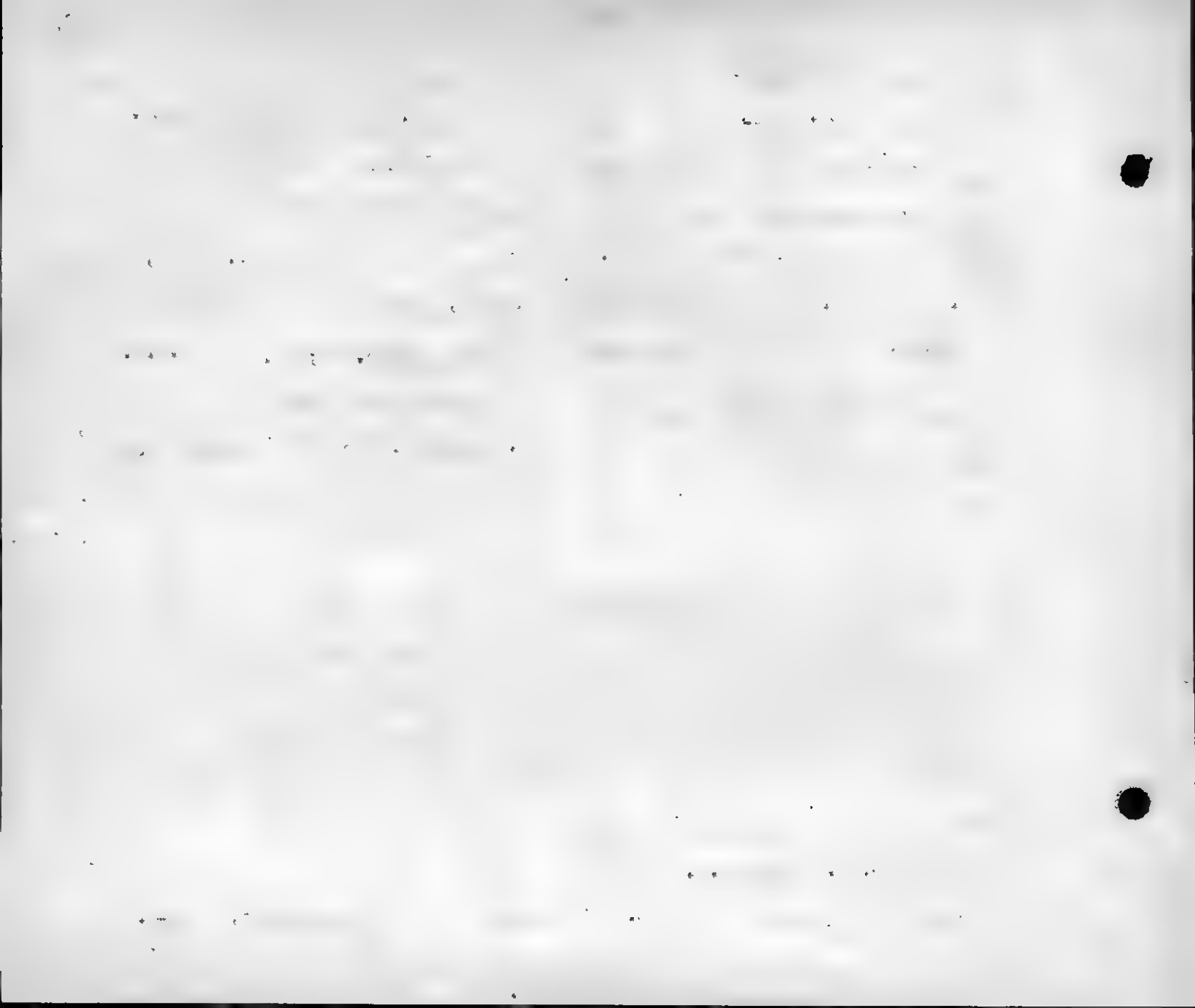
12225

Reg. Dist. No.

12253

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			c. LENGTH OF STAY IN TB <u>47 Yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3414 Chapman Road</u>				d. STREET ADDRESS <u>3414 Chapman Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank W. Doran</u>				4. DATE OF DEATH Month Day Year <u>Nov. 7, 1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>March 8, 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Shane Balto. Co.; Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Doran</u>				14. MOTHER'S MAIDEN NAME <u>Huldah Mc Collough</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>*****</u>		17. INFORMANT Address <u>Mrs. Daisie V. Doran 3414 Chapman Road Randallstown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rheumatic Heart Disease</u> (c), stating the underlying cause last. DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>5 yr. est.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>none 19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>none</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		
20f. (City or town) <u>none</u>			(County) <u>none</u>			(State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>D. D. Caples M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		11-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Randallstown, Md.</u>				(State) <u>Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>				ADDRESS <u>8728 Liberty Road</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H...</u>	
<u>Randallstown, Md.</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



SALARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Form 11/18/59

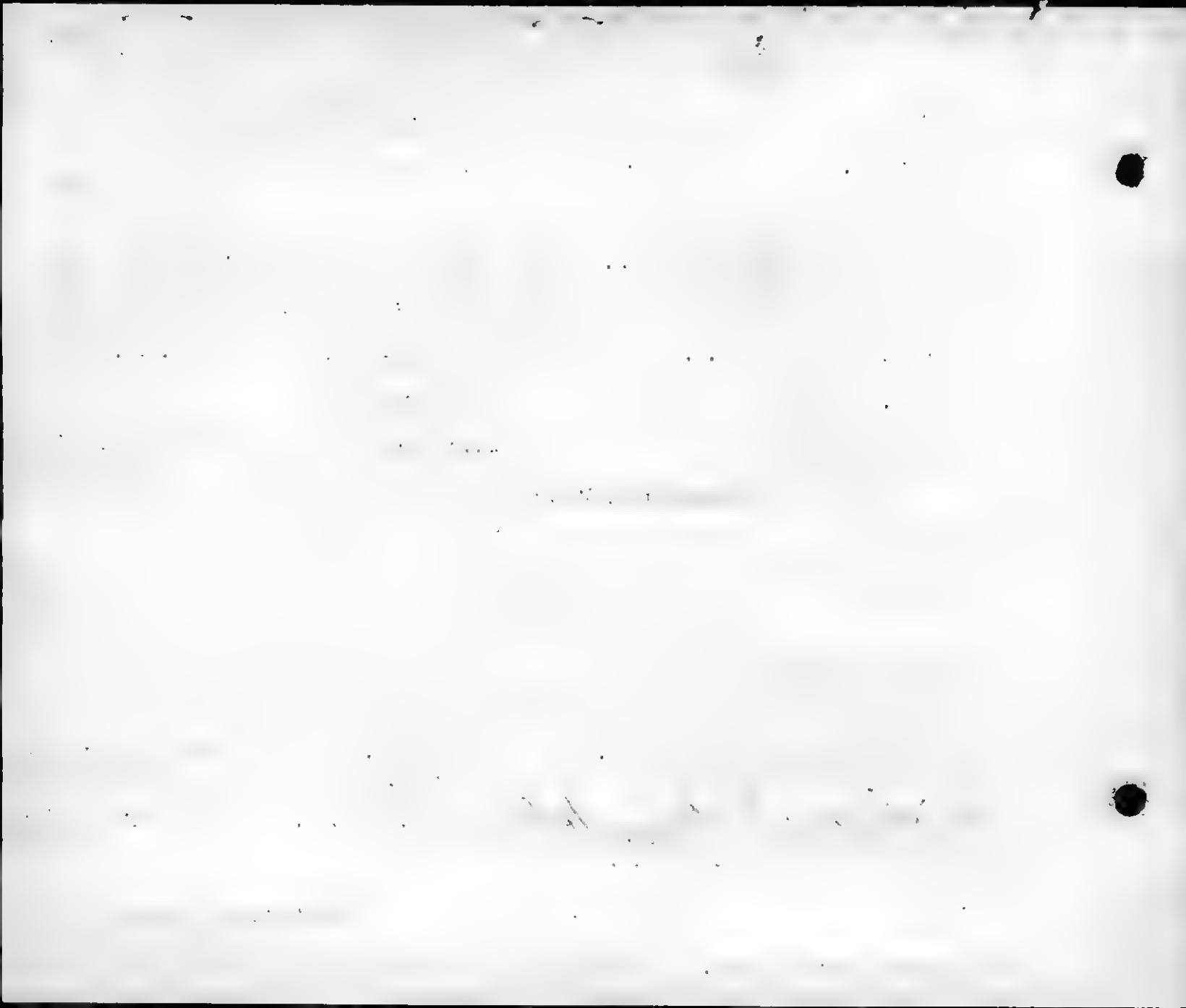
12254

CERTIFICATE OF DEATH

Reg. Dist. No.

12226

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Route 4, Box 229		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEROY Middle F. Last DORSEY				4. DATE OF DEATH Month November Day 8 Year 1959			
5. SEX White Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 30, 1924		9. AGE (In years last birthday) 35 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Elkridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel F. Dorsey				14. MOTHER'S MAIDEN NAME Olie Dunkerley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 219-18-6371		INFORMANT Address Clin. Recd VAH, Balto. 18, Md. Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 6 , 19 59 , to Nov. 8 , 19 59 , and that death occurred at 8:55 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO. 18, MD. FT. HOWARD DIVISION 11/9/59							
ACTUAL SIGNATURE <i>Lawrence J. Mazzei, M.D.</i>		PHYSICIAN'S NAME (Type) LAWRENCE J. MAZZEI, M.D.					
22a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Higinbotham Funeral Home				ADDRESS 106 Columbia Rd.		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kinn</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

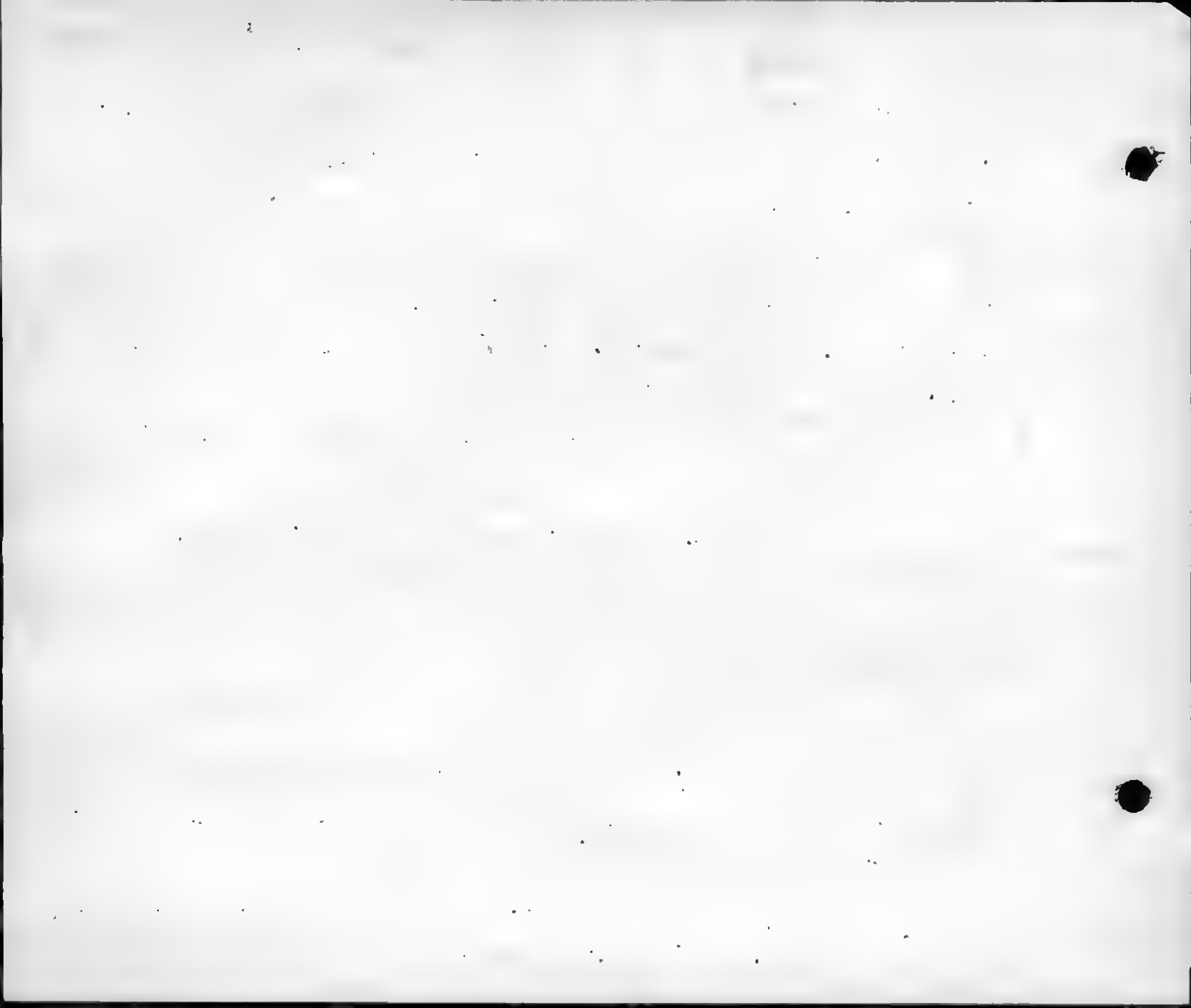
12255

CERTIFICATE OF DEATH

Reg. Dist. No.

12227

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE MARSH				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WHITE MARSH			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 ALLANDER ROAD.				e. STREET ADDRESS 812 ALLANDER ROAD.			
3. NAME OF DECEASED (Type or print) First GRAFTON Middle DULANEY Last DULANEY				4. DATE OF DEATH Month NOV Day 28 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 21, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) VIRGINIA GREEN CO	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME GEORGE WASHINGTON DULANEY				14. MOTHER'S MAIDEN NAME ALAMETA UNKNOWN.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-30-304			
17. INFORMANT JOHN SMITH				Address 812 ALLANDER ROAD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency Arteriosclerosis & Chronic Bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Arteriosclerosis & Chronic Bronchitis DUE TO (c) Arteriosclerosis & Chronic Bronchitis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. 27, 1958 to Nov. 28, 1959 that I last saw the deceased alive on Nov. 27, 1959 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 11-28-59							
ACTUAL SIGNATURE William G. Tyson M.D.				PHYSICIAN'S NAME (Type) Clifford F. Hudson Folk. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF DEC 2, 1959		22c. NAME OF CEMETERY OR CREMATORY PIVE GROVE	
22d. LOCATION (City, town, or county) PARKTON				22e. (State) MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Sassahn Funeral Home				ADDRESS 7401 Belair Road #6		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12256

CERTIFICATE OF DEATH

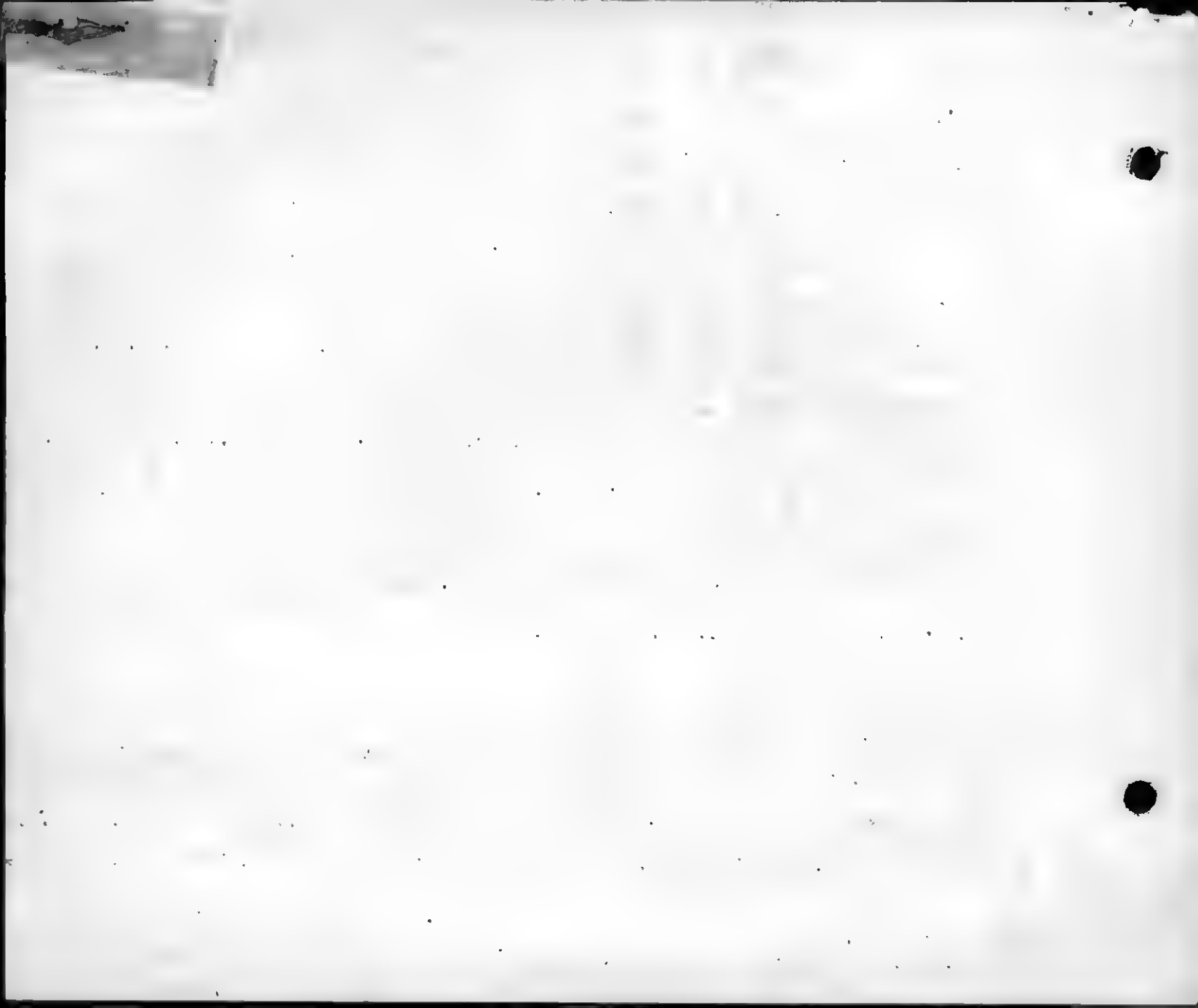
12228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 25 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore (17)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17)		d. STREET ADDRESS 1411 North Bruce Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		3. NAME OF DECEASED (Type or print) First JAMES Middle DUMPSON Last DUMPSON		4. DATE OF DEATH Month November Day 17 Year 19 59		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1902	
9. AGE (In years last birthday) 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Dumpson		14. MOTHER'S MAIDEN NAME Louisa Stevenson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-05-4461		17. INFORMANT Clin. Rec., VAH, Baltimore 18, Md., Ft. Howard Div.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO (b) UREMIA DUE TO (c) ACUTE AND CHRONIC RENAL DISEASE		INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES UNKNOWN UNKNOWN		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Pulmonary emphysema. 2. Obesity.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from October 23, 1959 to November 17, 1959 and that death occurred on November 17, 1959 at 4:34 AM from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>John W. Crawford</i>		ADDRESS (Street, city or town, state) VAH, BALTIMORE 18, MD., FT. HOWARD DIV.		DATE SIGNED 11/17/59		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIV.		DATE SIGNED 11/17/59		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE <i>George Kelson</i>		ADDRESS George Kelson Funeral Home 1348 N. Calhoun St. Balto. Md.		24a. REC'D BY REGISTRAR NOV 18 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 11-10-59 et

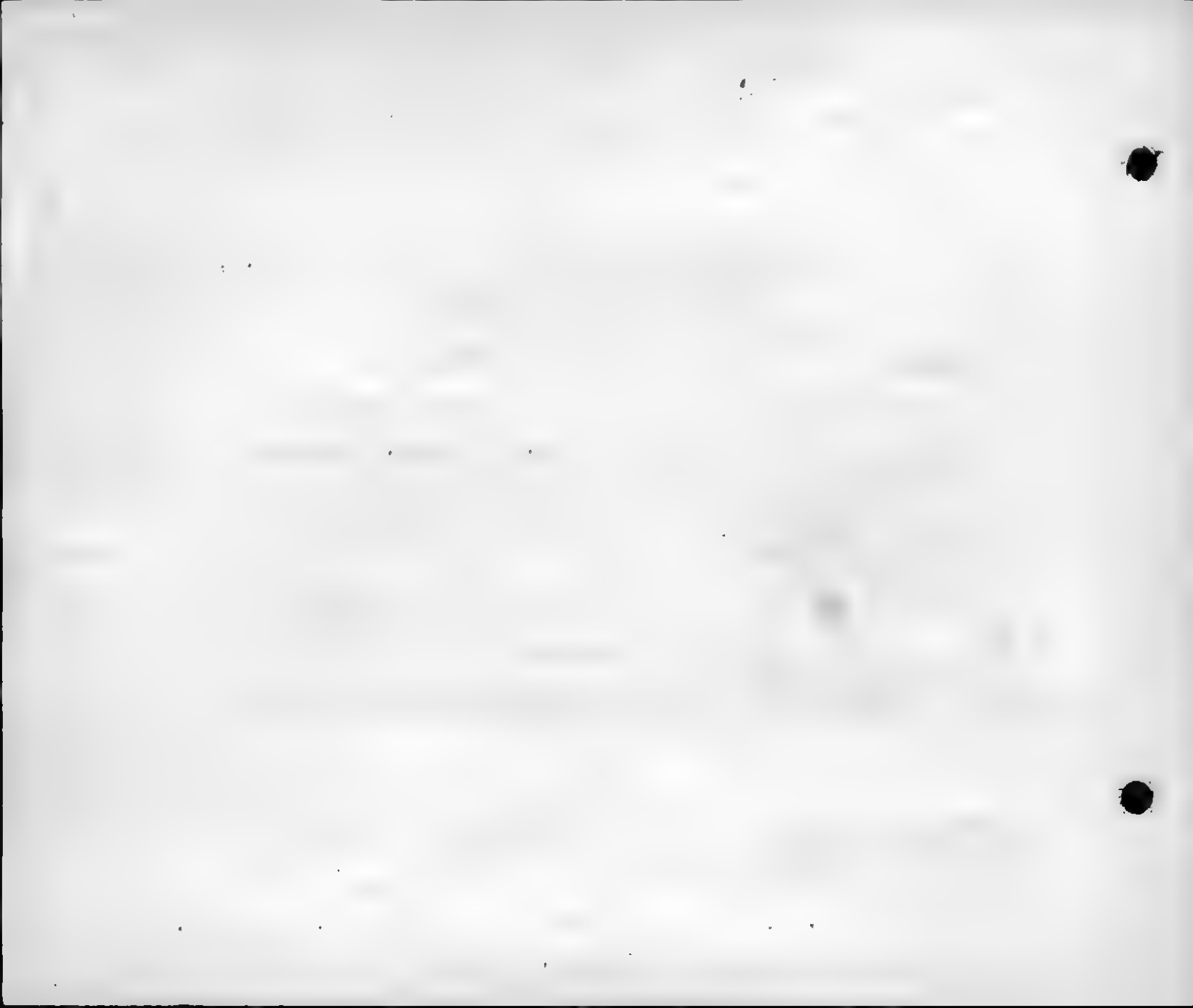
12257

CERTIFICATE OF DEATH

12229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 29	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lulie Mary Eckhardt		4. DATE OF DEATH Nov. 4, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/1882
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Schmelz		14. MOTHER'S MAIDEN NAME Fredericka Schmelz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mr. Arthur E. Rudolph		Address 414 Kensington Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio-sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left Hip Aug - 1959		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell in Room - Getting out of Bed -	
20c. TIME OF INJURY Month, Day, Year 10 - 8 / 29 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Augsburg Home		20f. (City or town) (County) (State) Balto - Ind. - Ind.	
21. I certify that I attended the deceased from Nov. 4 - 1959 , that I last saw the deceased alive on Nov. 3 - 1959 , and that death occurred at M. , from the causes and on the date stated above.		DATE SIGNED 11-6-59	
ACTUAL SIGNATURE Earl L. Chambers M.D.		ADDRESS (Street, city or town, state) 4108 Liberty Hts. Balto. Md.	
PHYSICIAN'S NAME (Type) Earl L. Chambers		ADDRESS 4108 Liberty Hts. Balto. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE JT Stansbury		ADDRESS 6411 Windsor Mill Rd.	
24a. REC'D BY REGISTRAR NOV 9 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12230

12258

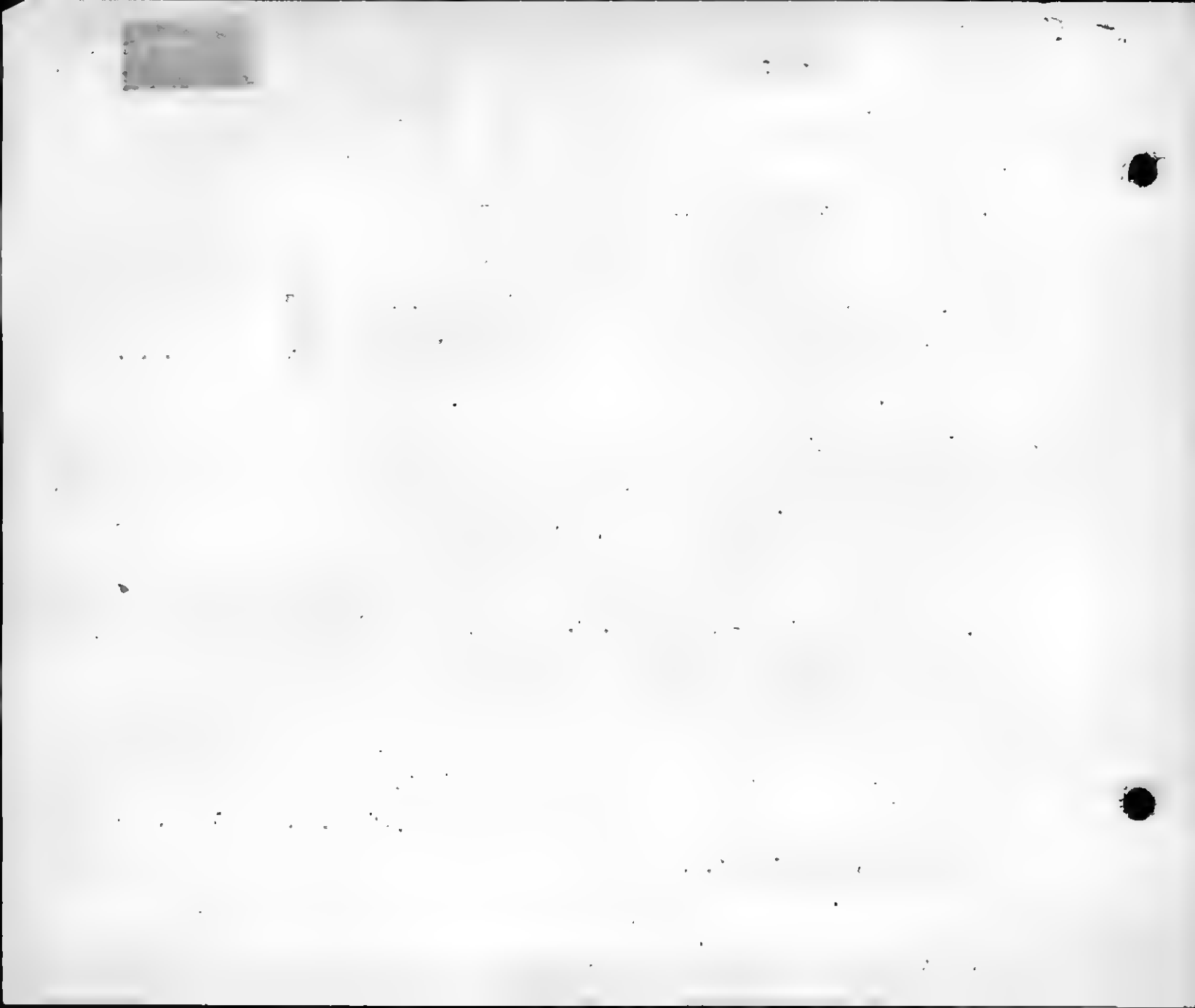
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST NEW MARKET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRENVILLE Middle L Last FOWLER		4. DATE OF DEATH Month November Day 26 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 31, 1907
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10b. KIND OF BUSINESS OR INDUSTRY LAW	
11. BIRTHPLACE (State or foreign country) Washington DISTRICT OF COLUMBIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OWEN H. FOWLER		14. MOTHER'S MAIDEN NAME ELIZA LEWIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) YES		16. SOCIAL SECURITY NO WW-11	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLEEDING ESOPHAGEAL VARICES 462.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PORTAL CIRRHOSIS OF LIVER (c) EDEMA OF LUNGS		INTERVAL BETWEEN ONSET AND DEATH FEW HOURS UNKNOWN FEW HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
1. Acute Pancreatitis - 2 to 3 Days. 2. Acute Pyelonephritis - 1 Week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 13, 1959 to November 26, 1959 , and that death occurred 11:15 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Armen Bogosian M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV. 11/27/59			
ACTUAL SIGNATURE Armen Bogosian			
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-1-59	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT INC		24a. REC'D BY REGISTRAR DEC 2 '59	
ADDRESS 6009 Harford Road Baltimore 14 Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

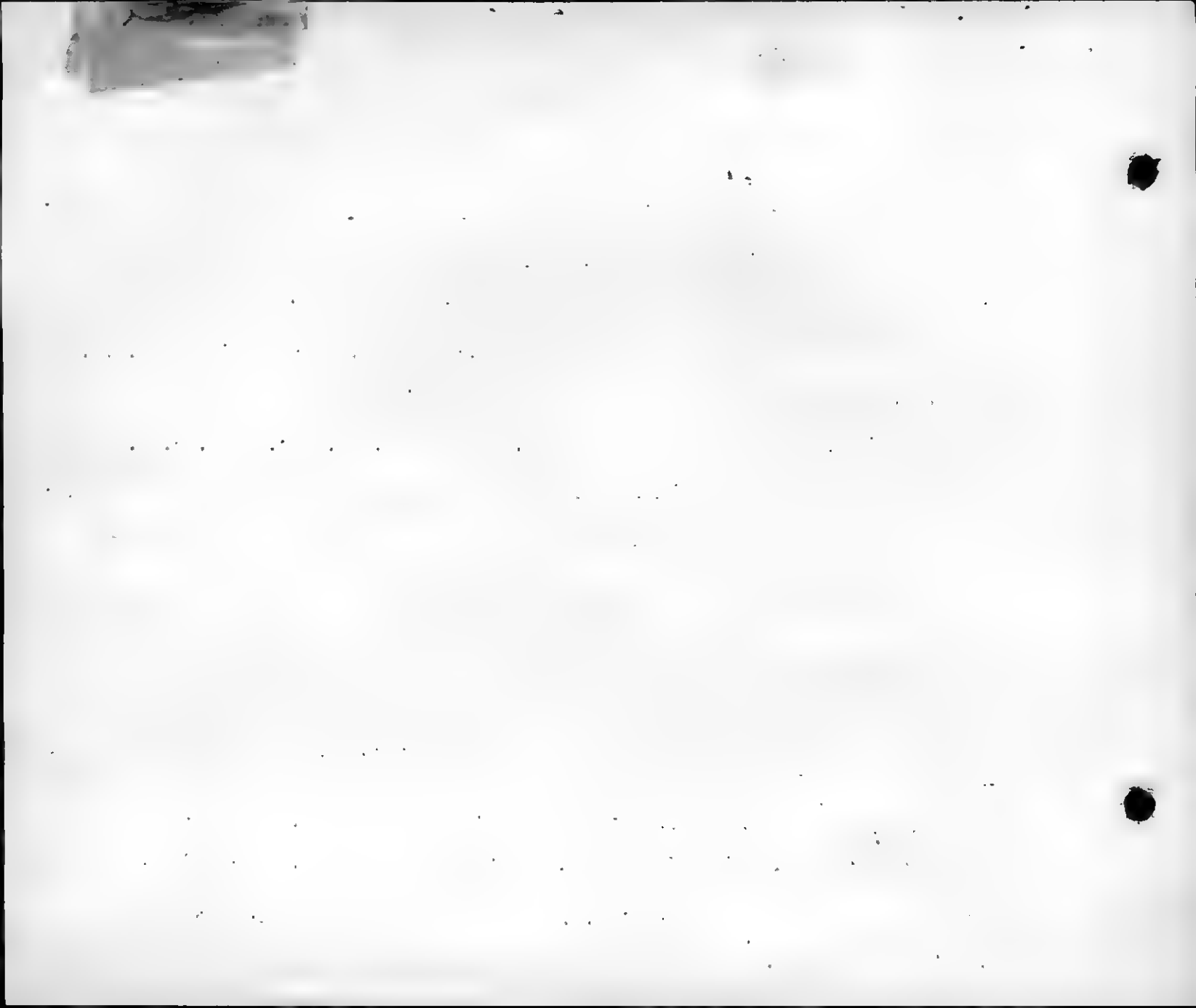
12231

12259

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 176 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 6400 Old Harford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH AUSTIN RACHA FRIDINGER				4. DATE OF DEATH Month Day Year November 22 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) York County, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Fridinger				14. MOTHER'S MAIDEN NAME Mary Stonecifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (If yes, give war or dates of service) SPANISH AMERICAN None		INFORMANT Address Clin. Records, Vet. Adm. Hosp. Balto. Md. Ft. Howard Div			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 473X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 to 2 DAYS 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 30 , 19 59 , to November 22 , 19 59 , and that death occurred at 2:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTIMORE, MD. FT HOWARD DIV 11/22/59 ACTUAL SIGNATURE George C. McElfatrick M.D. PHYSICIAN'S NAME (Type) GEORGE C. MC ELFATRICK M.D. VAH, BALTIMORE, MD. FT HOWARD DIV 11/22/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-25-59	22c. NAME OF CEMETERY OR CREMATORY MONKTON M.E. CHURCH CEMETERY	22d. LOCATION (City, town, or county) (State) MONKTON MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT, INC., BALTIMORE, MARYLAND			24a. REC'D BY REGISTRAR NOV 27 59	24b. REGISTRAR'S SIGNATURE William S. Howard			

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CERTIFICATE OF DEATH

12232

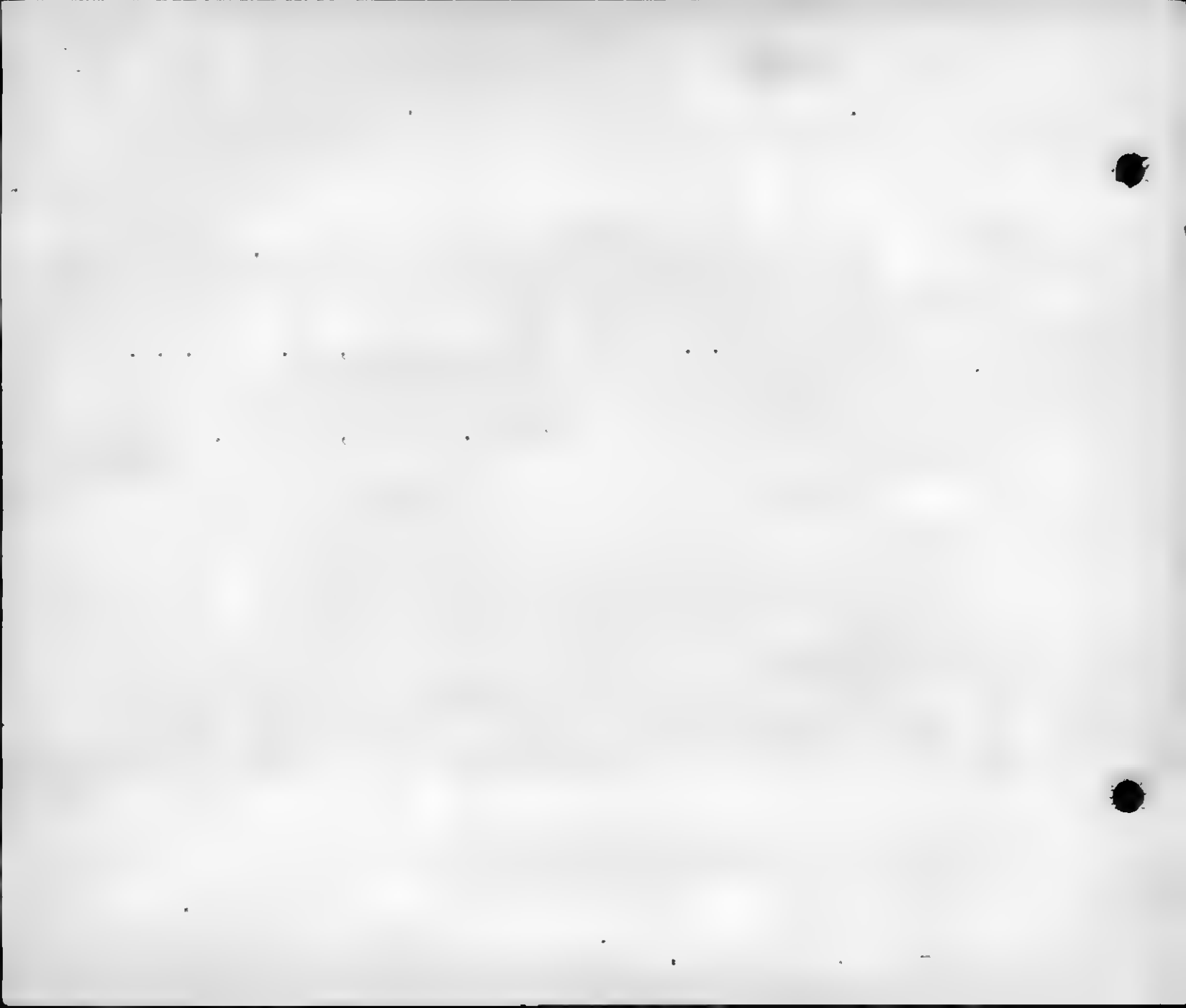
Reg. Dist. No.

12250

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1407 Shefford Road		d. STREET ADDRESS 1407 Shefford Road	
3. NAME OF DECEASED (Type or print) First GENEVIEVE Middle GARDINA Last		4. DATE OF DEATH Month Nov. Day 12 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1913
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY R.H. Donnelly Co	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hill		14. MOTHER'S MAIDEN NAME Elizabeth Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Frank R. Gardina, husband, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 48 , to Nov 12 , 19 59 , that I last saw the deceased alive on Nov 11 , 19 59 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert Scagnetti		ADDRESS (Street, city or town, state) 1724 W. Lombard St Baltimore Md	
PHYSICIAN'S NAME (Type) A. Scagnetti		DATE SIGNED 11-13-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/16/59	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Schimmeler Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
24b. REGISTRAR'S SIGNATURE C. J. & Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 223 File 4255 12/3/59 1WK

12261

CERTIFICATE OF DEATH

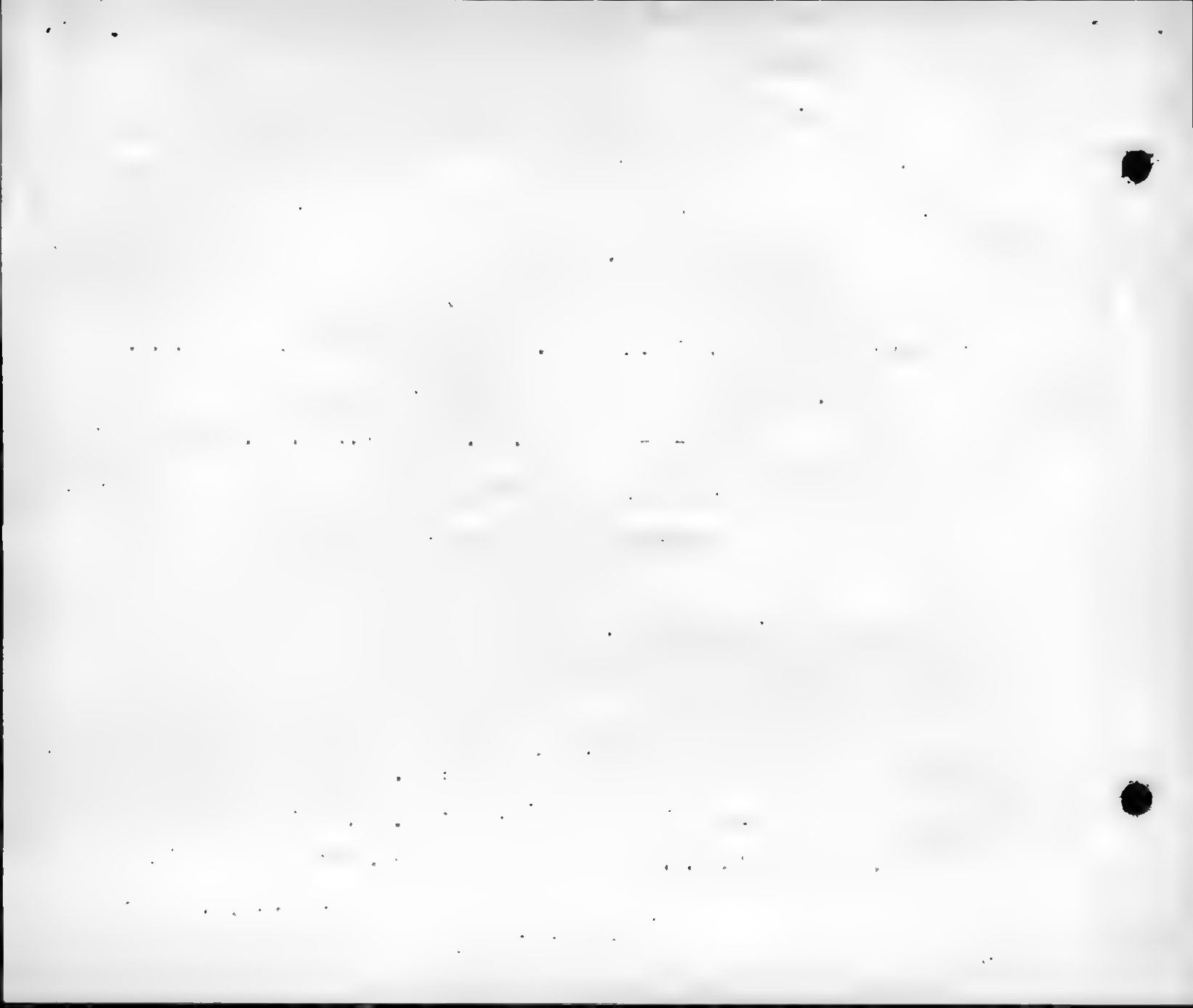
12233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 46 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALCAEUS Middle R. Last GARRETT		4. DATE OF DEATH Month November Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/92
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 6 Days 24 Hours 19 Min.	11. IF UNDER 24 HRS Months 6 Days 24 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Stieff Silver Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Garrett		14. MOTHER'S MAIDEN NAME Nettie Kershaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-01-7100	
INFORMANT Clin. Rec. VAH, Balto., Md.		Address Ft. Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH 6 HOURS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) CARCINOMA MIDDLE THIRD ESOPHAGUS. PULMONARY EMPHYSEMA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 9, 1959 to November 24, 1959 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO, MD. FORT HOWARD DIVISION DATE SIGNED 11/24/59			
ACTUAL SIGNATURE L. Bruce Smith M.D.		PHYSICIAN'S NAME (Type) L. BRUCE SMITH, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Horace Burgee Funeral Home, Baltimore, Maryland		24. REC'D BY REGISTRAR NOV 27 '59	
24b. REGISTRAR'S SIGNATURE Calvin S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



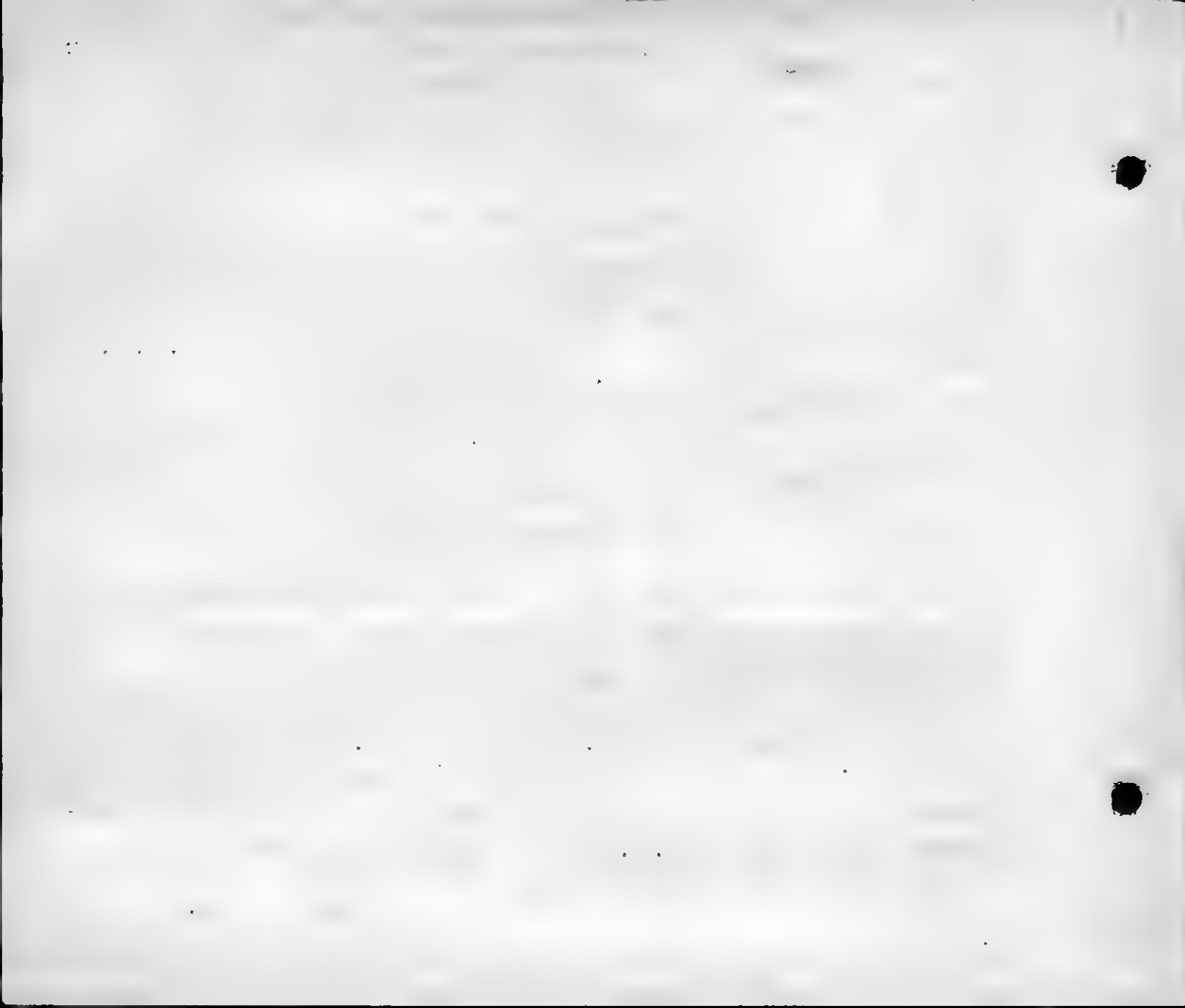
CERTIFICATE OF DEATH

Reg. Dist. No.

12262

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1 F Southway	
3. NAME OF DECEASED (Type or print) First Warren Middle Gerrits Last Gerrits		4. DATE OF DEATH Month November Day 5 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1886
9. AGE (In years lost birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plant man		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Gerrits		14. MOTHER'S MAIDEN NAME Amelia Granger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Volvulus of the sigmoid colon DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Cerebral vascular accident YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 27, 1959 to Nov. 5, 1959 , that I last saw the deceased alive on Nov. 5, 1959 , and that death occurred at 1:50 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 11-5-59			
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Wheaton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Garcke Sons & Daughter Inc		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
24b. REGISTRAR'S SIGNATURE Carlton L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

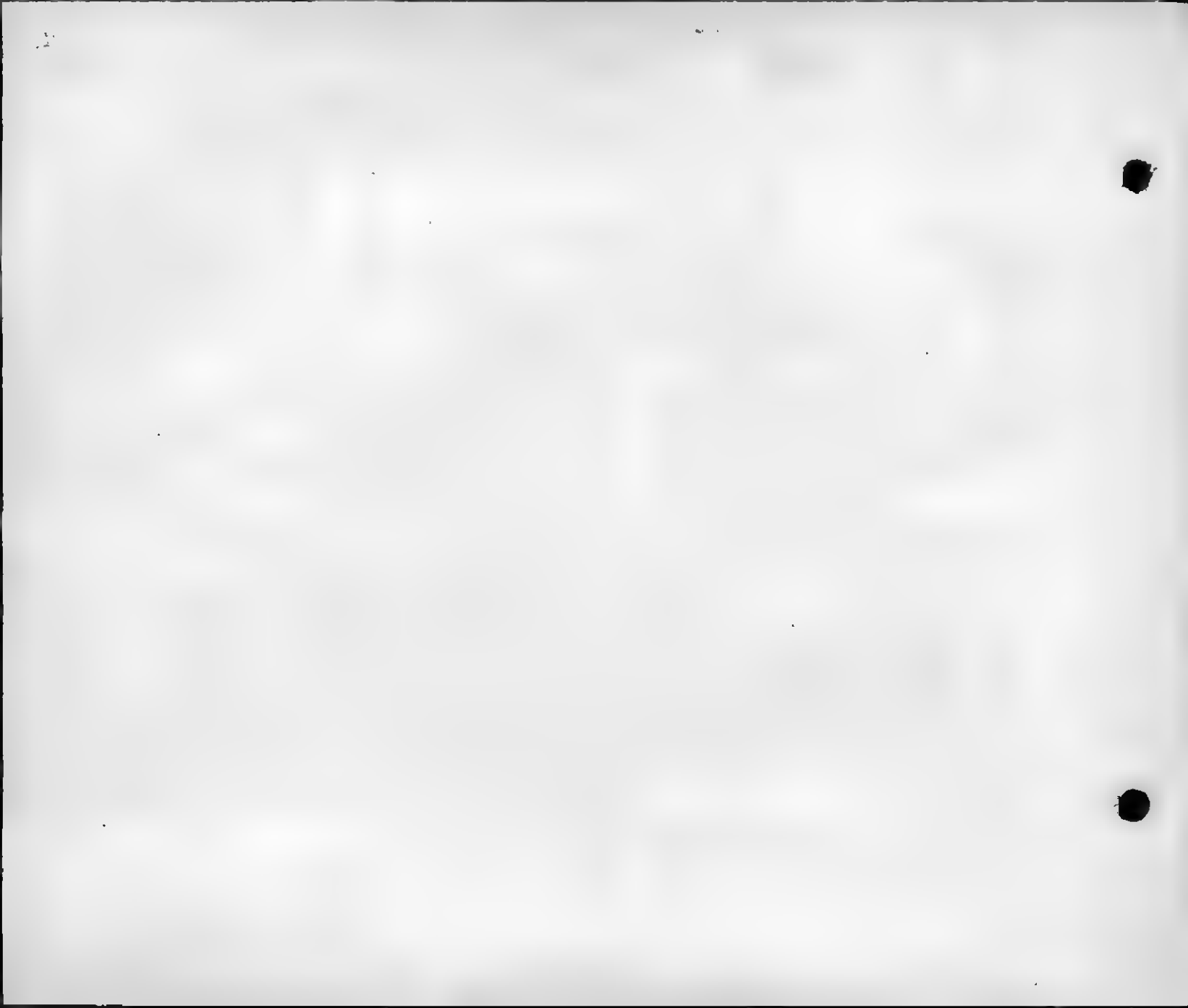
CERTIFICATE OF DEATH

Reg. Dist. No. 12235

12263

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliot City P.O.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jonnycake Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>M.</u> Last <u>Gettings</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29, 1862</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner of farm, Jonnycake Rd, Elliot</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Gettings</u>		14. MOTHER'S MAIDEN NAME <u>Anna Wedaker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Emma H. Gettings, Jonnycake Rd, Elliot City</u>		Address <u>Jonnycake Rd, Elliot City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cyclophritis</u> b. <u>Chronic urinary tract infection</u> c. <u>Benign prostatic hypertrophy</u> DUE TO <u>Diabetes mellitus; Arteriosclerotic ht. dis.</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; Arteriosclerotic ht. dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11</u> p. m. <u>30</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 11/6</u> , 19 <u>58</u> , to <u>11/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/6</u> , 19 <u>59</u> , and that death occurred at <u>1:30 P.M.</u> , from the cause and on the date stated above.			
ACTUAL SIGNATURE <u>Christian S. Mass</u> M.D.		ADDRESS (Street, city or town, state) <u>11 E. Chase Street, Baltimore 2, Md.</u>	
DATE SIGNED <u>11/3/59</u>			
PHYSICIAN'S NAME (Type) <u>Christian S. Mass</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Bepre 8725 Liberty Road Randallstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Emilia S. Kead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



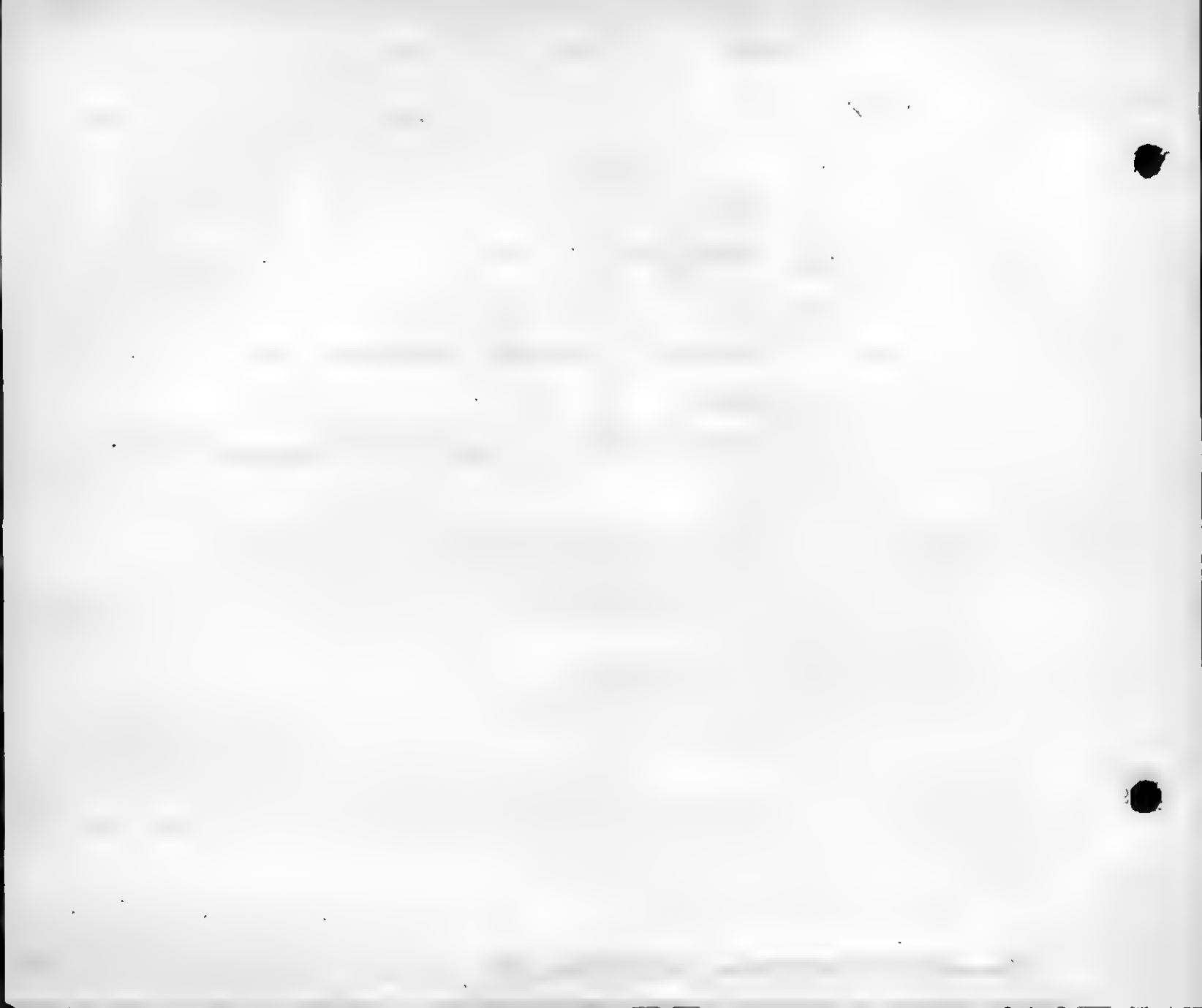
12264

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 Linden Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES MCKINSEY GILLESPIE</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6, 1906</u>
9. AGE (In years lost birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Division of Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Staunton, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Gillespie</u>		14. MOTHER'S MAIDEN NAME <u>P.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-03-8298</u>	
17. INFORMANT <u>Mrs Crystal Gillespie (same.)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery occlusion</u> (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>sudden</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 Nov 21</u> , 1959, that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above. <u>I did not attend deceased. Case discussed with Dr. Smith at medical examiner's office.</u> ACTUAL SIGNATURE <u>Richard N. Tillman</u> M.D. <u>3035 St. Paul St Baltimore, Md Nov 27, 1959</u> DATE SIGNED PHYSICIAN'S NAME (Type) <u>RICHARD N. TILLMAN, M.D.</u>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>North Canton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North Canton Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons, Co.</u>		24. REC'D BY REGISTRAR <u>Nov 27 '59</u>	
ADDRESS <u>4905 York Road,</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneel</u>	

TO HOSPITAL OR TO FUNERAL DIRECTOR. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film 252 11-24-59 et

12239

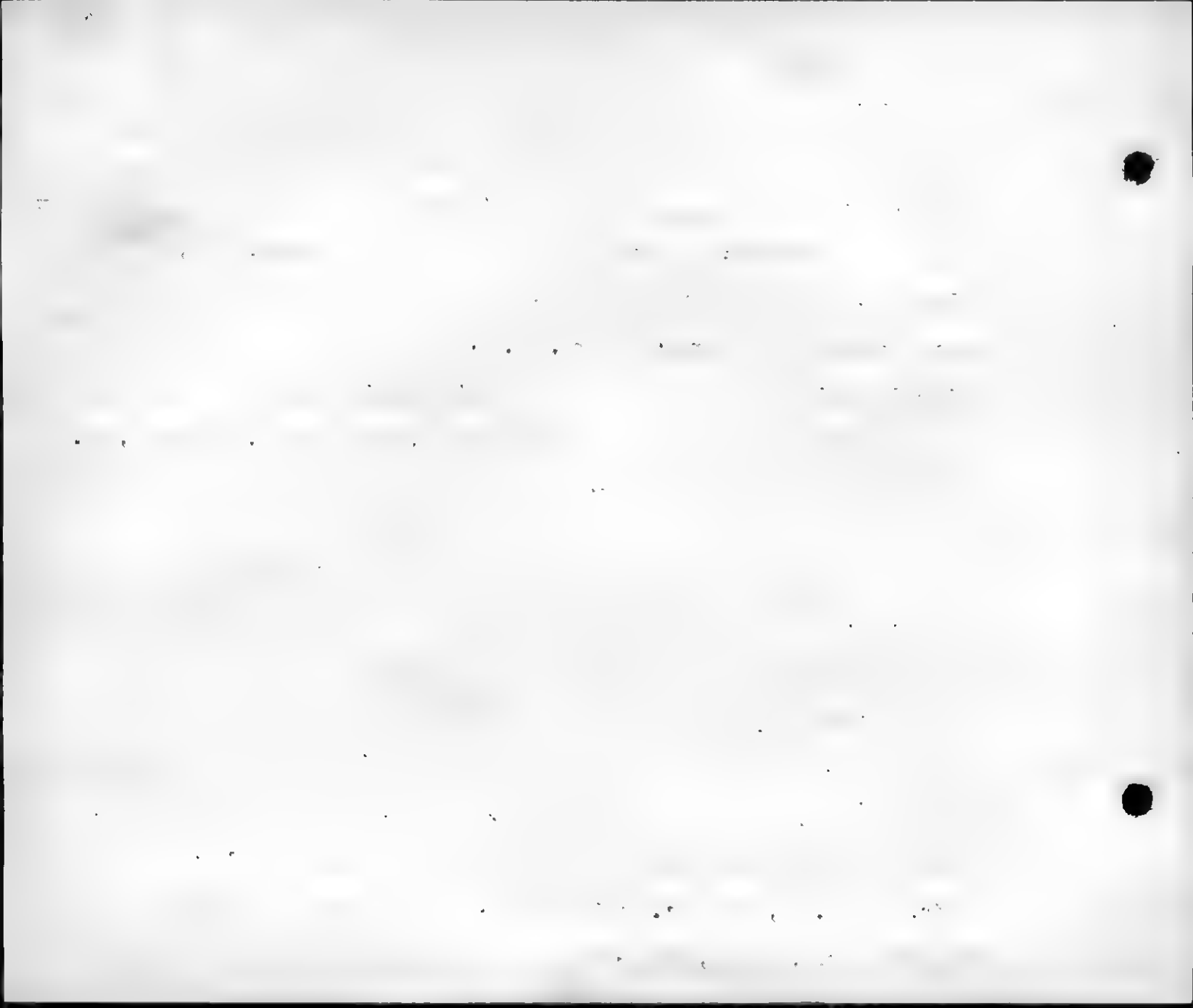
12265

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 565 Brook Road		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 565 Brook Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SALVATORE Middle GIZZI Last 4. DATE OF DEATH Month November Day 14, Year 1959		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH January 1, 1877 9. AGE (In years last birthday) yrs. 82 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Worker 10b. KIND OF BUSINESS OR INDUSTRY Concrete Const. Co. Italy 11. BIRTHPLACE (State or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Gizzi 14. MOTHER'S MAIDEN NAME diPennacchia Maria Gizzi (Maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None 16. SOCIAL SECURITY NO. INFORMANT Address Donado Gizzi, 565 Brook Rd., Towson 4, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4. DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ARTERIOSCLEROTIC HEART DISEASE DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 3-4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF HIP 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME	
20c. TIME OF INJURY Month. Day. Year Hour a. m. JUNE 19 59 p. m. 5 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME 20f. (City or town) (County) (State) BALTO. CO. MD.		21. I certify that I attended the deceased from 10/5 to 11/14 , 19 59 , that I last saw the deceased alive on 11/13 , 19 59 , and that death occurred at 3:20 A. M. from the causes and on the date stated above. ACTUAL SIGNATURE T. C. Siwinski ADDRESS (Street, city or town, state) 17 W. PENNA. AV. DATE SIGNED 11/17/59 PHYSICIAN'S NAME (Type) T. C. SIWINSKI TOWSON 4 MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Nov. 17, 1959 22c. NAME OF CEMETERY OR CREMATORY Mt. Maria Cemetery 22d. LOCATION (City, town, or county) (State) Towson, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland ADDRESS 17 W. PENNA. AV. 24a. REC'D BY REGISTRAR NOV 19 59 24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12266

CERTIFICATE OF DEATH

12240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>17yr9mth4dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>Linthicum, Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Fred</u> Last <u>Glanzer</u>		4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 6, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Rail Road</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany U.S.A.</u>	
13. FATHER'S NAME <u>William Glanzer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hannibal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure with pleural effusion</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 13, 1959</u> , to <u>November 25, 1959</u> , that I last saw the deceased alive on <u>Nov. 25, 1959</u> , and that death occurred at <u>1:05p</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>11-25-59</u>	
ACTUAL SIGNATURE <u>Aristides Simopoulos</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>Aristides Simopoulos, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov. 28, 1959</u>	<u>Meadowridge Cem.</u>	<u>BALTO. MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schwalb</u>		24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>	
ADDRESS <u>3512 Frederick Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. & H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12267

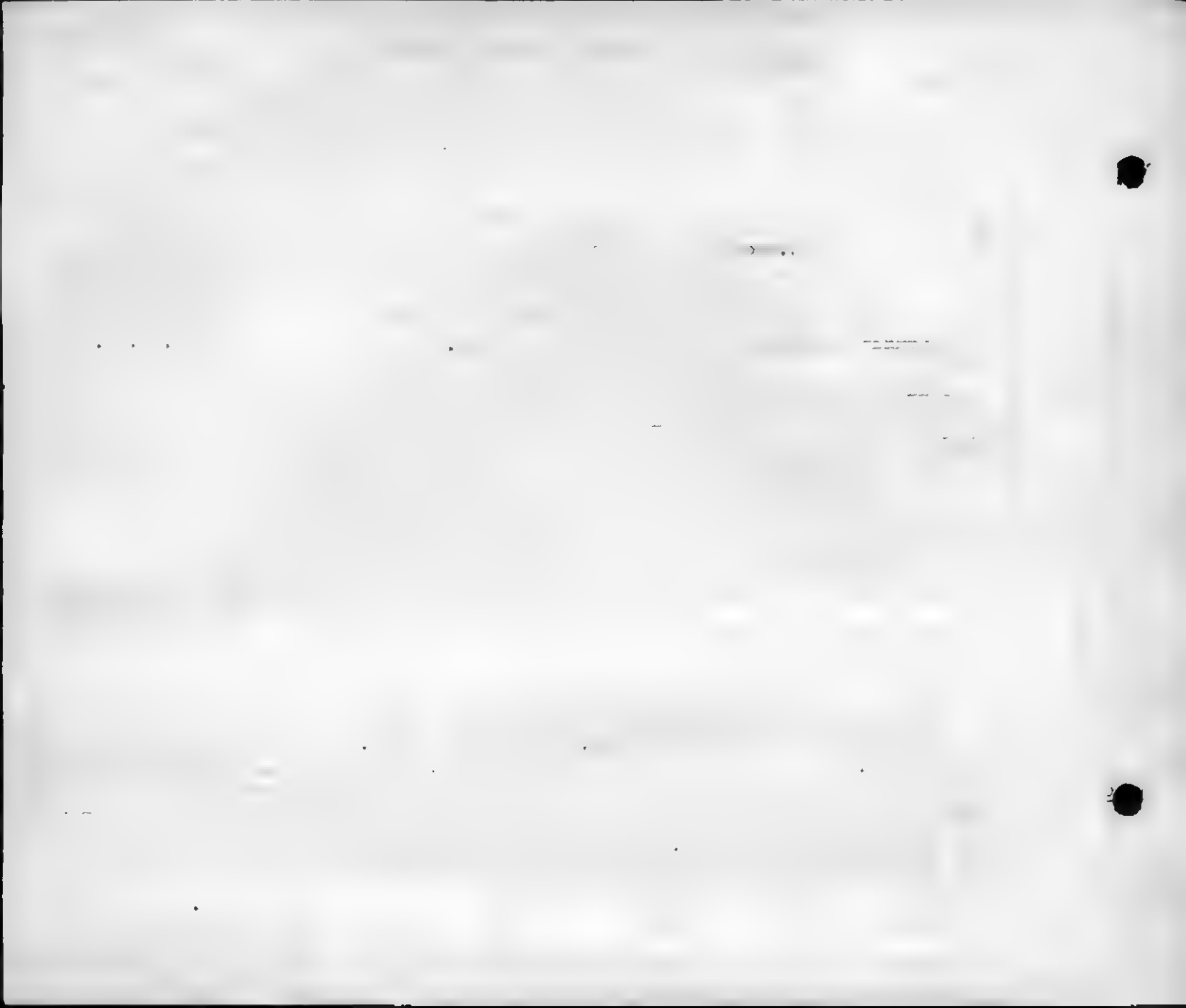
CERTIFICATE OF DEATH

Reg. Dist. No.

12241

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1mth 22dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 6510 Brighton Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Frank W. Golebieski (or Goblieski)				4. DATE OF DEATH Month Day Year November 9 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Unknown 10/3/1910	9. AGE (In years last birthday) 49? yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Balto. Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Joseph Golebieski				14. MOTHER'S MAIDEN NAME Viola Miros			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) unknown NO		16. SOCIAL SECURITY NO. 215-09-9431		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver with hemorrhage 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Sept. 17 , 19 59 , to Nov. 9 , 19 59 , that I last saw the deceased alive on Nov. 9 , 19 59 , and that death occurred at 1:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 11-9-59							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/12/59	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				24a. REC'D BY REGISTRAR DATE NOV 10 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

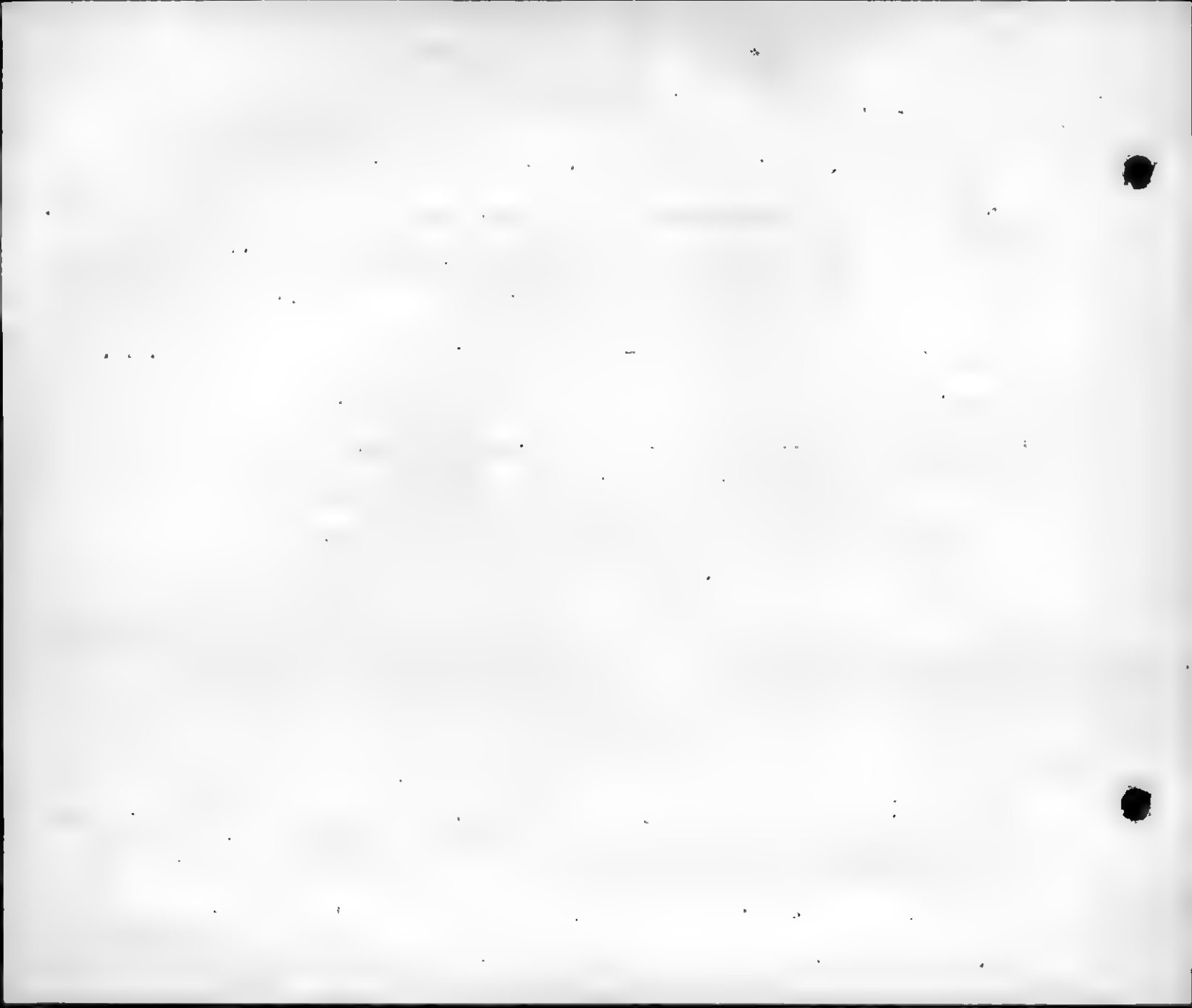
12268

CERTIFICATE OF DEATH

Reg. Dist. No.

12242

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
c. LENGTH OF STAY IN 1b 50 yrs.		d. STREET ADDRESS 4234 Parkside Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Graff Last Graff		4. DATE OF DEATH Month 11 Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/98
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 11 Days 27 Hours 19 Min 59	IF UNDER 24 HRS. Months 11 Days 27 Hours 19 Min 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Graff	
14. MOTHER'S MAIDEN NAME Barbara Schmidt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		INFORMANT Address Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of stomach content and focal broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 471X DUE TO (c) 471X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter W. Rieckert		ADDRESS (Street, city or town, state) Baltimore 14, MD	
PHYSICIAN'S NAME (Type) Peter W. Rieckert		DATE SIGNED 11/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/30/59	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		24a. REC'D BY REGISTRAR DEC 1 59	
ADDRESS 4210 Belair Road		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	



12269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN IB <u>45yrs 4mth 11dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>Hagerstown, Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>S.</u> Last <u>Groshon</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 14, 1877</u>
9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Jasper Groshon</u>		14. MOTHER'S MAIDEN NAME <u>Alice Weddell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>			
DUE TO <u>Generalized arteriosclerosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u>			
DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the rectum</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>Nov. 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 19</u> , 19 <u>59</u> , and that death occurred at <u>7:15a</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Stella Wachser</u>		M. D. <u>SPRING GROVE STATE HOSPITAL</u> <u>11-19-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachser, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Creagerstown Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Creagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Greager</u>		ADDRESS <u>Thurmont, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b. <i>1905</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3022 East Ave</i>		d. STREET ADDRESS <i>3022 East Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Jane Margaret Suba</i>		4. DATE OF DEATH <i>Nov 17 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 21 1879</i>
9. AGE (In years last birthday) <i>79</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Birmingham England</i>	
11. BIRTHPLACE (State or foreign country) <i>Birmingham England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Dolan</i>		14. MOTHER'S MAIDEN NAME <i>Jane Colley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Don't know</i>	
17. INFORMANT <i>Don</i>		Address <i>3022 East Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Complete debilitation</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinomatosis</i> DUE TO (c) <i>Gastric Adenocarcinoma</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 mos.</i> <i>18+ mos.</i> <i>18 mos.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardiac Asthma</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 16 1959</i> to <i>Nov 17 1959</i> , that I last saw the deceased alive on <i>Nov 16 1959</i> , and that death occurred at <i>8:00 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>9005 Hartford Rd BALTO 14 Md</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T. KASIK JR</i>		DATE SIGNED <i>11/17/59</i>	
22a. BURIAL, CREMATION, or other disposal <i>BURIAL</i>	22b. DATE THEREOF <i>11/21/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>NEW CATHEDRAL</i>	22d. LOCATION (City, town, or county) (State) <i>BALTIMORE Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>CHAS. F. EVANS & SON</i>		ADDRESS <i>8802 HARTFORD RD</i>	
24a. REC'D BY REGISTRAR <i>Nov 19 59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

CERTIFICATE OF DEATH

Reg. Dist. No.

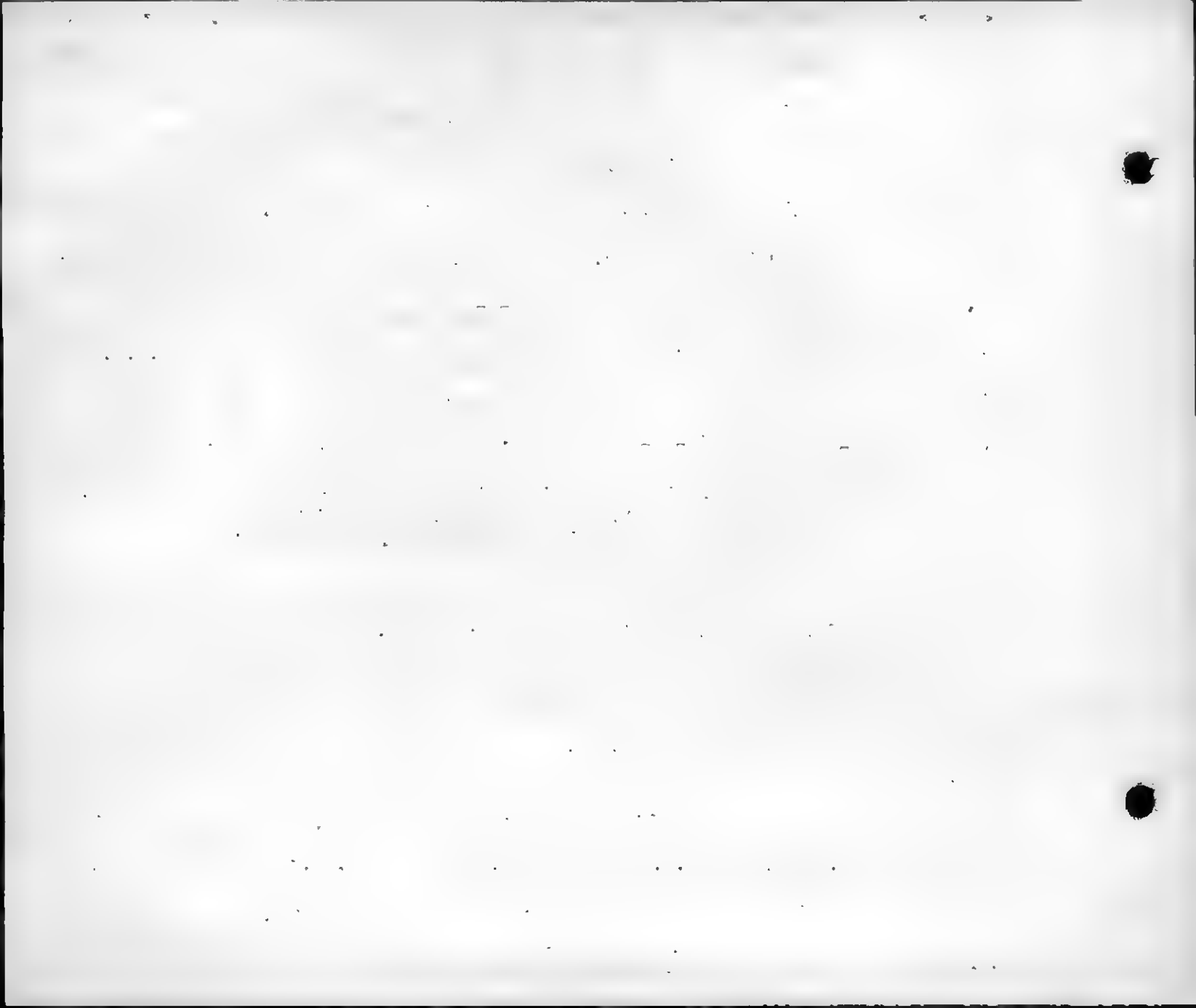
12245

12271

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 48 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (16) 2V-1 4	
d. STREET ADDRESS 1817 ASHBURTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle S. Last HALL		4. DATE OF DEATH Month November Day 23 Year 1959	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEVEDORE		10b. KIND OF BUSINESS OR INDUSTRY SHIPPING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC HALL		14. MOTHER'S MAIDEN NAME MARY DIGGS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 217-03-0091	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS WITH METASTASES TO PERICARDIUM, MYOCARDIUM, LUNGS, DIAPHRAGM AND PERITRACHEAL, PERIAORTIC AND HILAR LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AND PERITRACHEAL, PERIAORTIC AND HILAR LYMPH NODES (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PASSIVE CONGESTION OF LUNG, LIVER AND SPLEEN. INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER 6, 1959 to NOVEMBER 23, 1959 that I was over the deceased since 11/24/59 and that death occurred at 4:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town state) BALTIMORE VAH, FT. HOWARD DIVISION MD DATE SIGNED 11/24/59 ACTUAL SIGNATURE John W. Crawford M.D. BALTIMORE VAH, FT. HOWARD DIVISION 11/24/59 PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION 11/24/59			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/27/59	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A Rice Funeral		24a. REC'D BY REGISTRAR Nov 25 '59	
24b. REGISTRAR'S SIGNATURE Charles A. Rice			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained in hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr2mth23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 940 Ashland Court	
3. NAME OF DECEASED (Type or print) First Benson Middle Cornelius Last Hardesty		4. DATE OF DEATH Month 11 Day 24 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1870
9. AGE (In years last birthday) yrs 89		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Hardesty		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			
DUE TO Arteriosclerotic Cardiovascular Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 30, 1959 , to Nov. 24, 1959 , that I last saw the deceased alive on Nov. 24, 1959 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas		M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 11/24/1959	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS		Catonsville 23, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/28/59	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Pickens & Sons - Baltimore		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE William S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12197

CERTIFICATE OF DEATH

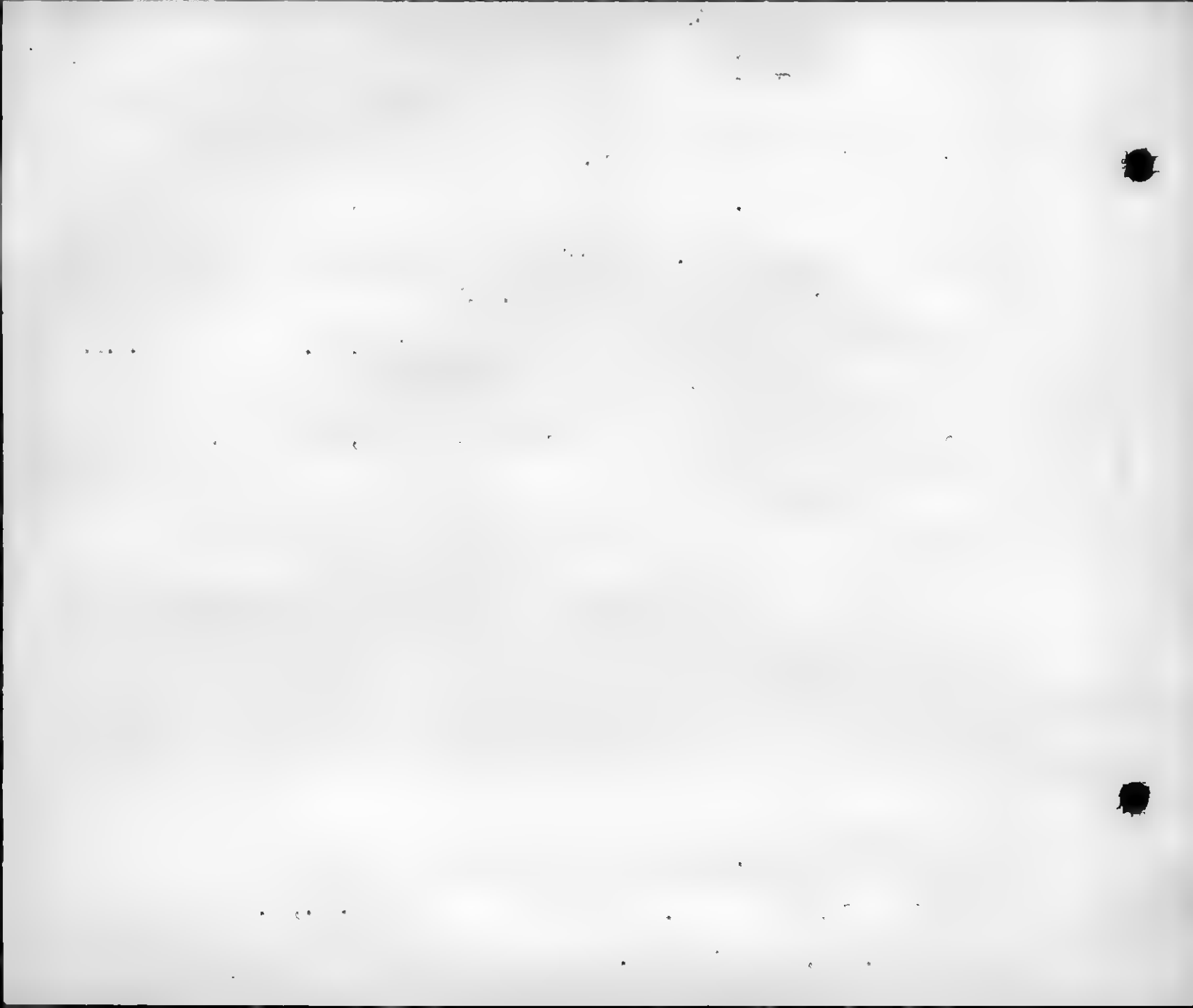
12247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turner Statino		c. LENGTH OF STAY IN 1b 55yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Ash Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
3. NAME OF DECEASED (Type or print) First Middle Last Ida M. Harris		4. DATE OF DEATH Month November Day 4, Year 1959	
5. SEX F	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1874 1870
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Lawrenceville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Beryl Franklin		14. MOTHER'S MAIDEN NAME Sarah Franklin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs Ida M. Drewitt, 201 Ash Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Hypertension & arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH NOO 4-57 unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1957 to November 4, 1959 that I last saw the deceased alive on November 4, 1959 and that death occurred at P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 107 N. Main St. Dundalk Md. DATE SIGNED			
ACTUAL SIGNATURE J. J. Thomas		PHYSICIAN'S NAME (Type) J. J. Thomas	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/7/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	22d. LOCATION (City, town, or county) (State) A.A. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles R. Law, 802 Madison Ave.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12273

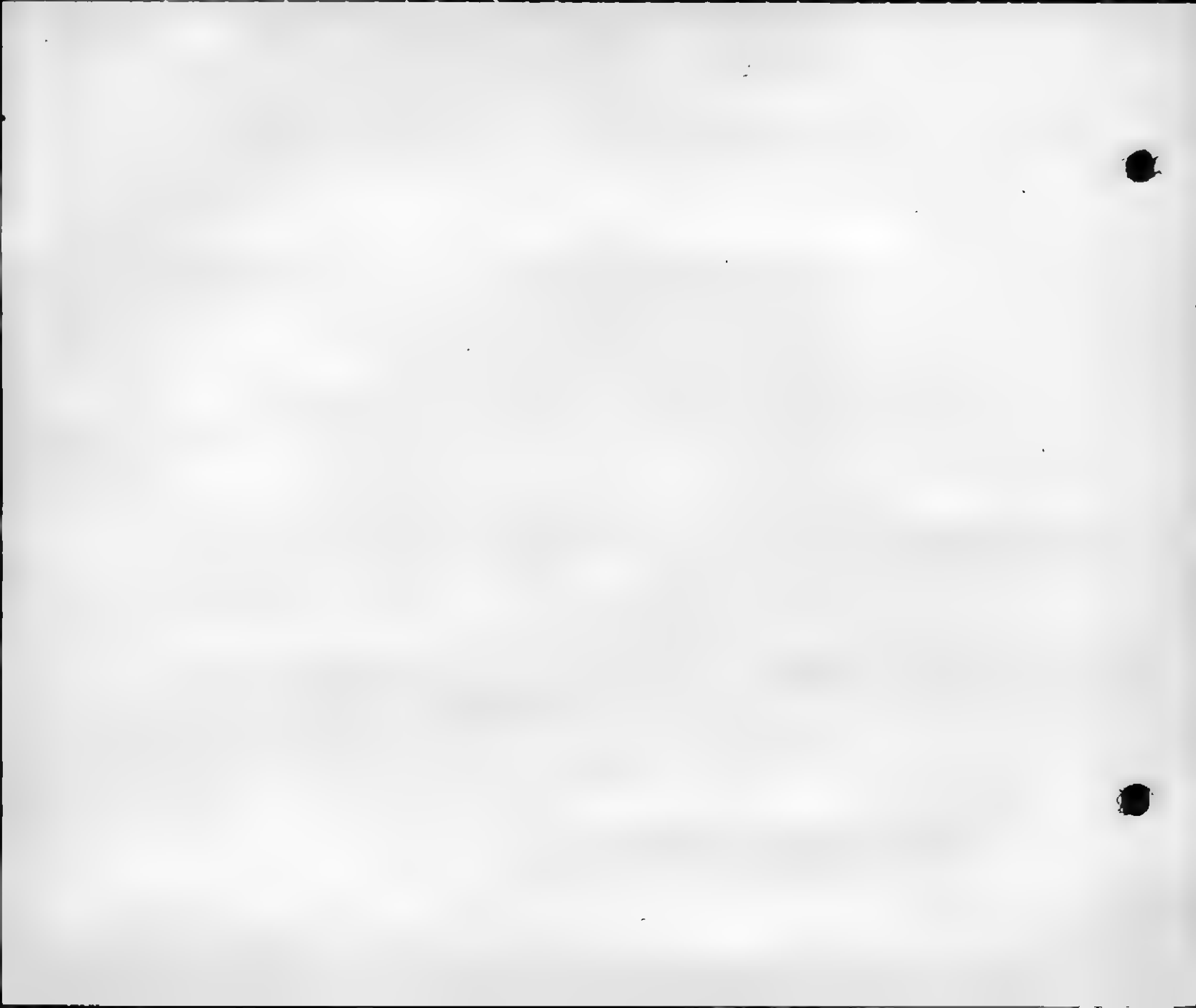
CERTIFICATE OF DEATH

12248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ARM</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GLEN ARM.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT #1 BOX 640 GLEN ARM ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Thomas Hayes</u>				4. DATE OF DEATH Month Day Year <u>Nov 28 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 16, 1895</u>		9. AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JEROME HAYES.</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE UNKNOWN.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>218-03-3894</u>		17. INFORMANT Address <u>LORETTA V HAYES RT #1 BOX 640 RD. GLEN ARM</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion - infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (c). (b) <u>Arteriosclerotic CVD</u> (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 1959</u> to <u>Nov. 28, 1959</u> , that I last saw the deceased alive on <u>Nov. 24, 1959</u> , and that death occurred at <u>3:39</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willsboro Co. Tyngs</u> M.D. <u>Kingsville Md. 11-28-59</u> Patient under treatment by PHYSICIAN'S NAME (Type) <u>Clifford F. Hudson</u> F.R.C. Md. seen by me at time of death							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laasahn Funeral Home 7401 Belair Rd Balt</u>				24a. REC'D BY REGISTRAR <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12274

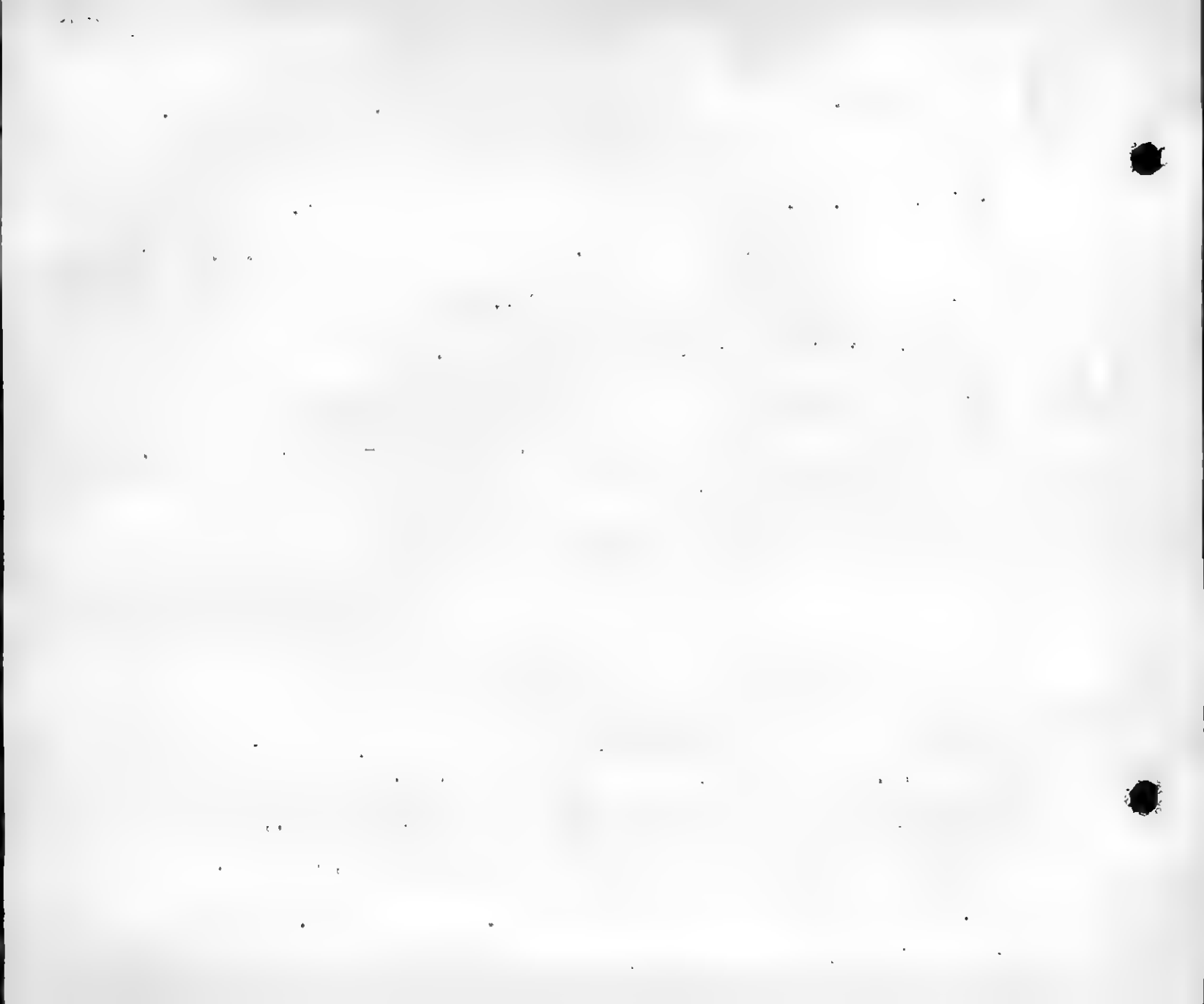
CERTIFICATE OF DEATH

12249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5915 Robindale Rd.				d. STREET ADDRESS 5915 Robindale Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANKLIN Middle C. Last HECK				4. DATE OF DEATH Month Nov. Day 18 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 21, 1887	
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant (rtd)				10b. KIND OF BUSINESS OR INDUSTRY Wholesale Drugs		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME George Heck				14. MOTHER'S MAIDEN NAME Katherine Pinschmidt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO no			
17. INFORMANT Mrs. Helen Heck - 5915 Robindale Rd., Ctnsvle				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis, Acute 4. 1.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) unknown DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 19 59 , to Nov. 19 59 , that I last saw the deceased alive on Nov. 16 , 19 59 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 Mallow Hill Ave., Baltimore 29, Maryland. DATE SIGNED 11/20/59							
ACTUAL SIGNATURE Leo J. Gaver M.D.				PHYSICIAN'S NAME (Type) Leo J. Gaver			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/21/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
22d. LOCATION (City, town, or county) (State) Balto. Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lickner & Sons - Balto				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE James L. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12275

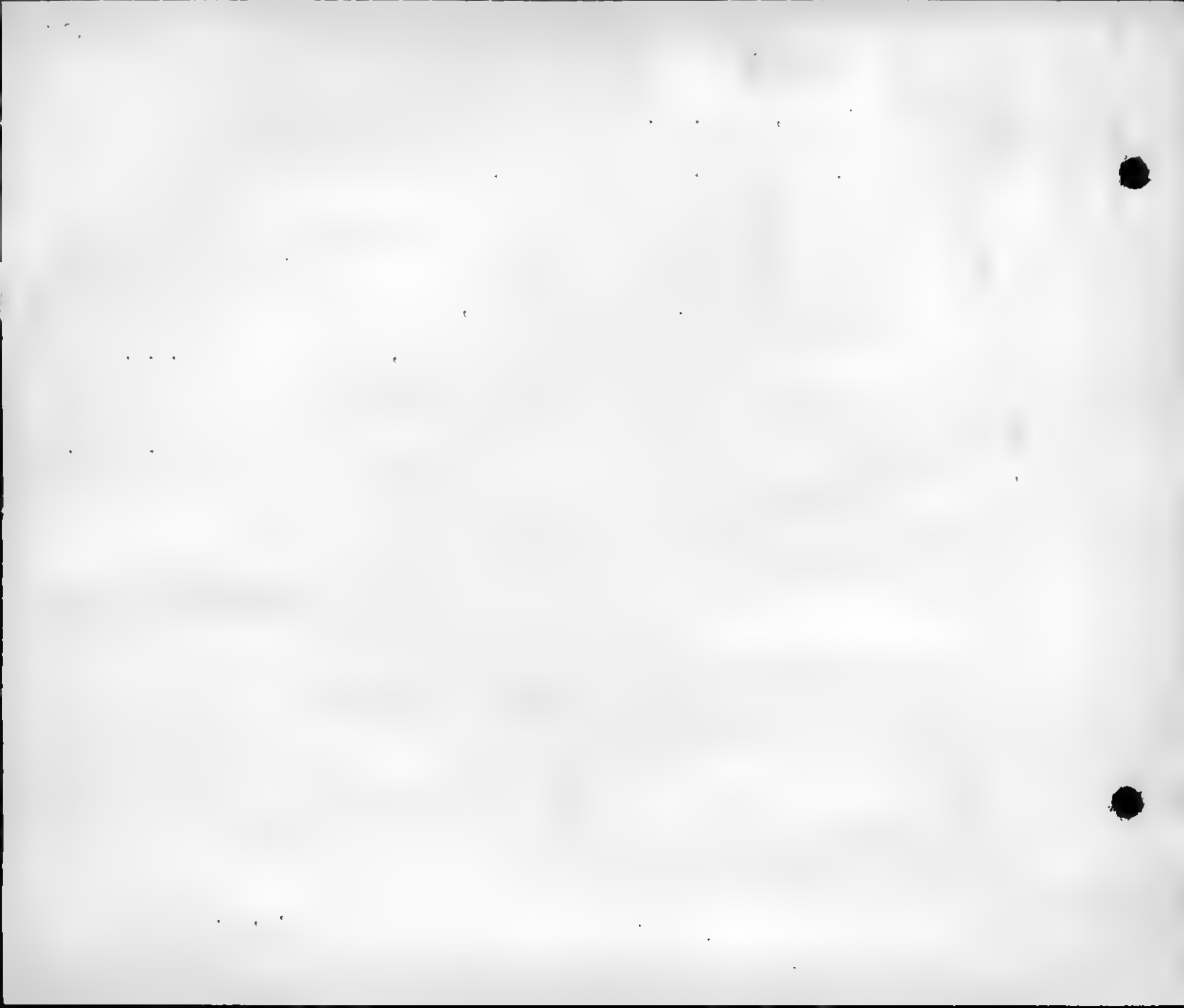
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Middleborough, Balto. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleborough, Essex, Md.		c. LENGTH OF STAY IN 1b Middleborough, Essex, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleborough, Essex, Maryland		d. STREET ADDRESS 314 West Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 314 West Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Genevieve Marie Heil				4. DATE OF DEATH Month Day Year November 28 1959			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1900	9. AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis O'Connell				14. MOTHER'S MAIDEN NAME Catherine Buberl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 213-20-3104		17. INFORMANT Address Genevieve Schub 7714 Gough St. Balto. 24			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephrosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH 4 wks. Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1958, to 11/28, 1959, that I last saw the deceased alive on 11/27, 1959, and that death occurred at 10:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Platt		M.D. 424 Eastern Ave.		ADDRESS (Street, city or town, state) Essex, Md.		DATE SIGNED 11/30/59	
PHYSICIAN'S NAME (Type) J. PLATT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE A. Christine Brydzinski				24a. REC'D BY REGISTRAR DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12276

CERTIFICATE OF DEATH

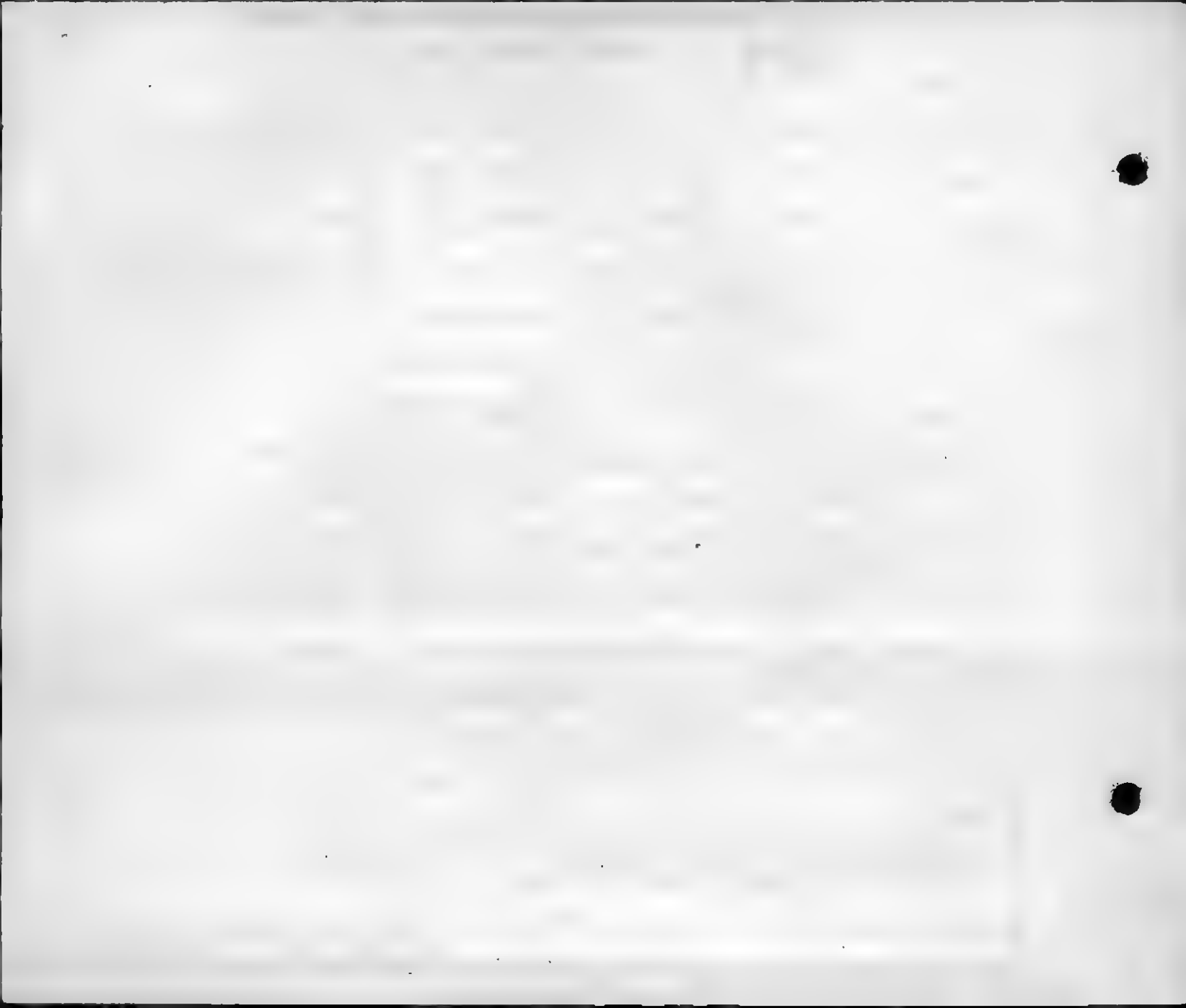
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton RD #1</u>		c. LENGTH OF STAY IN 1b <u>28 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Georges Creek Rd</u>				d. STREET ADDRESS <u>Georges Creek Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Mary</u> Last <u>Heiss</u>				4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 15 1885</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>21</u> Days <u>06</u> Hours <u>00</u> Min <u>00</u>		IF UNDER 24 HRS. Hours <u>00</u> Min <u>00</u> Sec <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Edward Royston</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Shearer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Name <u>Claude Heiss</u> Address <u>Parkton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cardio-Vascular Disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>May 12, 1954</u> to <u>Nov 21, 1959</u> , that I last saw the deceased alive on <u>Nov 16, 1959</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				DATE SIGNED <u>11-21-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Fortin, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12252

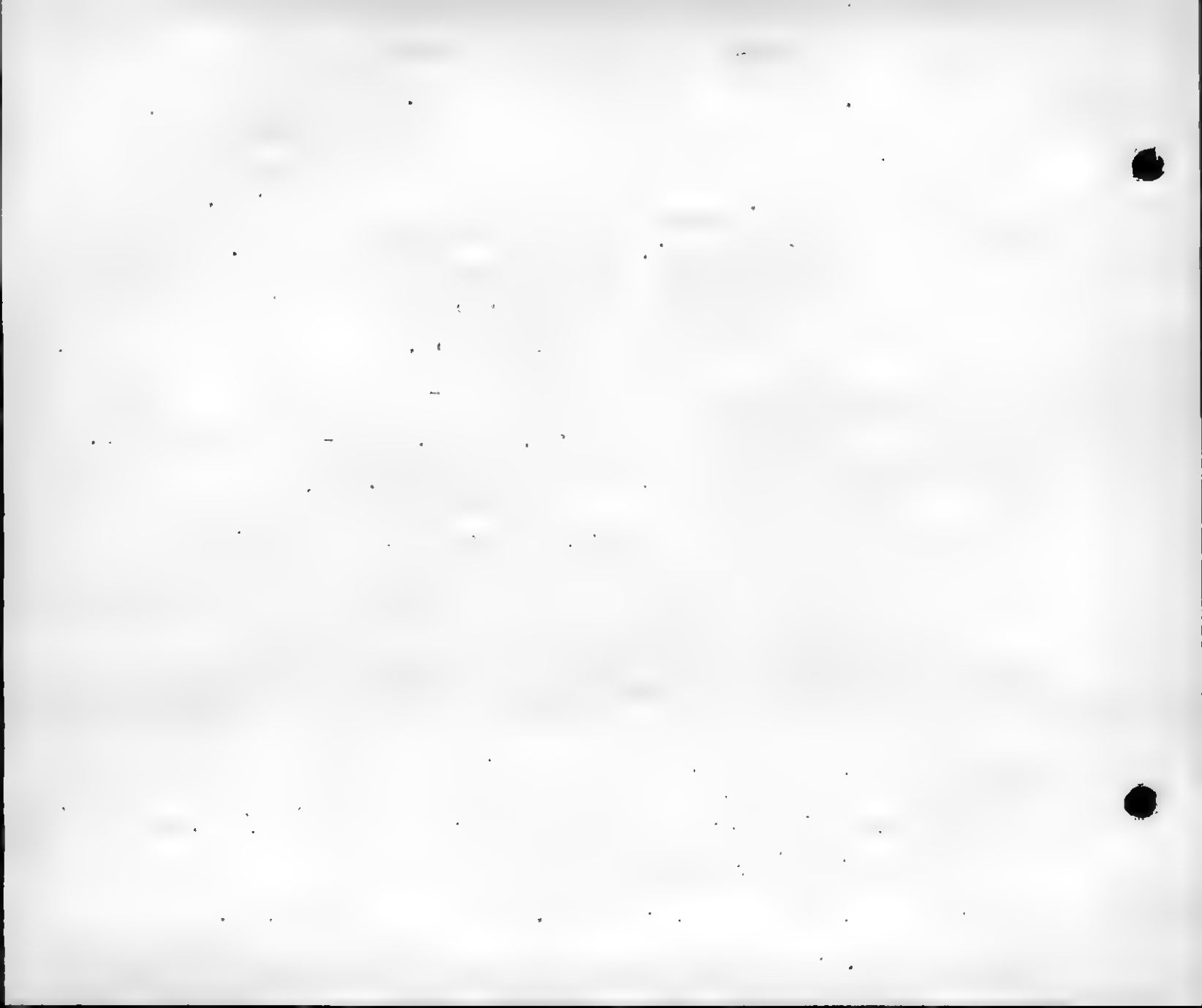
12277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
c. LENGTH OF STAY IN 1b Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3605 Stoneybrook Rd.		d. STREET ADDRESS 3605 Stoneybrook Rd.	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle W. HELINE Last 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Mar. 9, 1901 9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		4. DATE OF DEATH Month Nov. Day 26, Year 19 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Work		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? .	
13. FATHER'S NAME John Henry Heline		14. MOTHER'S MAIDEN NAME Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Norma E. Heline-3605 Stoneybrook Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4301 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 10 MINUTE
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10, 1958 to 11/26, 1959 that I last saw the deceased alive on 11/24, 1959 , and that death occurred at 8:24 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin K. Pugh		ADDRESS (Street, city or town, state) DATE SIGNED Nov 27 1959	
PHYSICIAN'S NAME (Type) EDWIN K. PUGH, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William J. Schenck		24a. REC'D BY REGISTRAR DATE NOV 30 '59	
ADDRESS Baltimore		24b. REGISTRAR'S SIGNATURE William J. Schenck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. The law requires that the death certificate be executed within 24 hours after death. Page 4. The law requires that the death certificate be executed within 24 hours after death. Page 4.



12253

12278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1104 BAKER AVE.		d. STREET ADDRESS 1104 BAKER AVE.	
3. NAME OF DECEASED (Type or print) First IVANA Middle - HENIGMAN Last		4. DATE OF DEATH Month NOV. Day 5 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 15, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOSEPH RAUNIKAR		14. MOTHER'S MAIDEN NAME AGNES CHERNICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Rudolph H. Henigman - 1104 Baker Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pyelonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/1 , 1958, to 11/5 , 1959, that I last saw the deceased alive on 11/3 , 1959, and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11-7-59	Lorraine Park Cem.	Balto Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. J. J. Funeral Home - Catonsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Halethorpe)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4603 Lincoln Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia G. Middle Henry Last		4. DATE OF DEATH Month November Day 21 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Gillingham		14. MOTHER'S MAIDEN NAME Georgiana G. McCoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Donald D. Henry 1233 Circle Drive #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Sudden 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 18, 1959 to Nov 21, 1959 that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frederick Beitler		DATE SIGNED Nov 23-59	
PHYSICIAN'S NAME (Type) Frederick Beitler, M.D.		1014 Francis Avenue #27	
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial	22b. DATE THEREOF 11-24-59	22c. NAME OF CEMETERY OR CREMATORY Louison Park Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR NOV 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>None</u> 7		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTE) <u>Essex Rd. (Villa Nova)</u> <u>Robb Nursing Home</u>		d. STREET ADDRESS <u>2524 Druid Park Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Rosswell</u> First <u>G.</u> Middle <u>High</u> Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>	IF UNDER 24 HRS Hours <u>1</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Rosswell Grover High</u>	
14. MOTHER'S MAIDEN NAME <u>Georgianna ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>215-09-2892</u>		17. INFORMANT Address <u>Mr. Frank G. Hite - 3504 Greenspring Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intermittent C.V.D.</u> <u>442X</u> DUE TO (b) <u>Nephritis, chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Prostatic hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Varicosis of legs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Sept 21</u> , 1957, to <u>Nov 7</u> , 1959, that I last saw the deceased alive on <u>Nov 8</u> , 1959, and that death occurred at <u>4:10 P. M.</u> from the causes and on the date stated above	
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>1632 Reisterstown Road</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner 4 Lewis - Baltimore</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William J. Lickner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12256

12281

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NURSING HOME - 3 ROBERTS AVE.</u>		d. STREET ADDRESS <u>6120 BALTO. NATL. PIKE</u>	
3. NAME OF DECEASED (Type or print) First <u>ESTELLA</u> Middle <u>D.</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 31, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>COLUMBUS, GA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOSHUA DILLARD</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MRS. BEulah H. JACKSON</u>		Address <u>6102 BALTO. NATL. PIKE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arterio-sclerotic Heart</u> DUE TO (c) <u>Disease</u> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct. 15th, 1959</u> , to <u>Nov. 1st, 1959</u> , that I last saw the deceased alive on <u>Nov. 1st, 1959</u> , and that death occurred at <u>9.45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. F. Maloney, M.D.</u>		ADDRESS (Street, city or town, state) <u>57 Winters Lane</u> DATE SIGNED <u>11/2/59</u>	
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>		<u>Catonville-28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 5, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN MEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halland Funeral Home</u>		ADDRESS <u>1631</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12257

12282

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2935 North Wind Rd.</u>				d. STREET ADDRESS <u>2935 North Wind Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>J.</u> Last <u>Holland</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Cont.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>John Holland</u>				14. MOTHER'S MAIDEN NAME <u>Delhea Clancey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Margaret J. Holland</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177x Carcinoma of Prostate</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 49</u> , 19 <u> </u> , to <u>Nov 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>59</u> , and that death occurred at <u>7:48</u> P.M. from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Harold H. Burns</u>				ADDRESS (Street, city or town, state) <u>8106 Harford Rd.</u>		DATE SIGNED <u>11-1-59</u>	
PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12283

CERTIFICATE OF DEATH

1. NAME OF DECEASED
(Type or Print)

Ellsworth A. Hurlock

2. DATE OF DEATH
Bar. Dist. No.

November 8, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore City County

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE 212 Gaywood Road - Baltimore 12

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 12D. STREET ADDRESS (If rural, give location)
212 Gaywood Road

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

May 30, 1893

9. AGE (In years last birthday)

66

If Under 1 Year If Under 24 Hours
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman10B. KIND OF BUSINESS OR INDUSTRY
Auto. parts

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Elmer E. Hurlock

14. MOTHER'S MAIDEN NAME

Mary I. Allen

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
YES W.W.II16. SOCIAL SECURITY NO.
212-07-4795

17. INFORMANT

Alice K. Hurlock, 212 Gaywood Road

ADDRESS

18. 374X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Hemiplegia, left April 1959
DUE TO right Sept 27, 1959(B) hypertensive vascular disease 3 yrs
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.Decubitus Ulcers & Gynitis

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

21D. TIME (Month) (Day) (Year) Hour OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 10/29/59 to 11/8/59, that (I) (~~we~~) last saw the deceased alive on 11/8, 1959, and that in (my) (~~our~~) opinion death occurred at 12:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Wm. Cook

23B. ADDRESS

8358 Loch Raven Blvd #4

23C. DATE SIGNED

11/9/5924A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

24B. DATE

11-11-59

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION (City, town, or county) (State)

Pikesville

DATE RECEIVED BY 59
REGISTRAR'S SIGNATURE

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Towson, Inc., 1050 York Road

THIS IS A PERMANENT RECORD

PLEASE TYPE, OR WRITE PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

5 CERTIFICATE MUST BE FILTH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER I



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12284

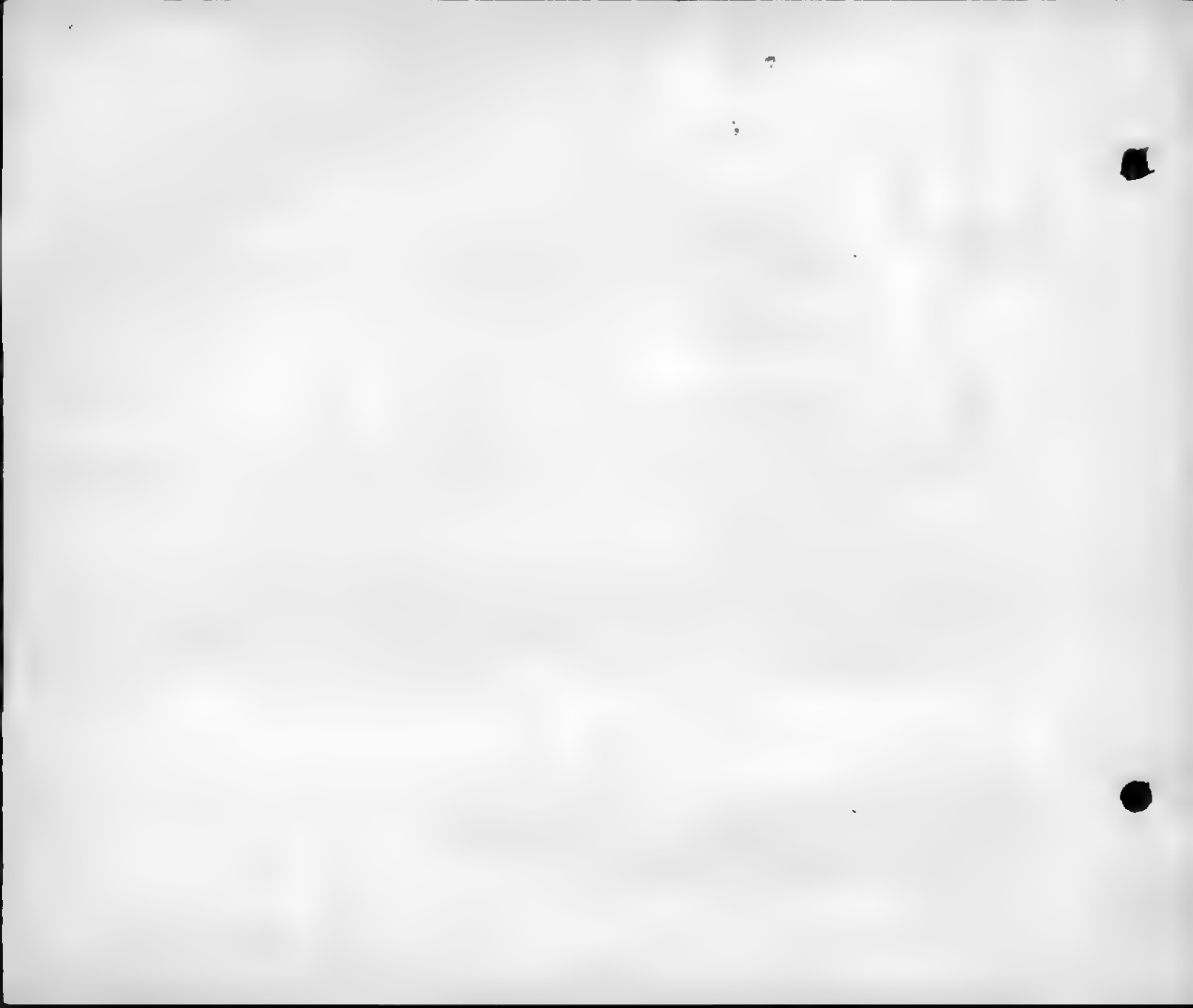
CERTIFICATE OF DEATH

12259

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sheppard Pratt Hosp.</i>		d. STREET ADDRESS <i>225 Westwood Rd, Wardour</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>Amos Francis Hutchins</i>		4. DATE OF DEATH Month Day Year <i>Nov 11 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 28, 1884</i>
9. AGE (In years last birthday) <i>75</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Physician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Surgeon</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY. <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Love Hutchins</i>		14. MOTHER'S MAIDEN NAME <i>Anna Mary Bowen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes 1917-19</i>		16. SOCIAL SECURITY NO. <i>Hosp. Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar Pneumonia</i>			
DUE TO <i>4x</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i>			
DUE TO <i>3yr +</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 23, 1959</i> , to <i>Nov 11, 1959</i> , that I last saw the deceased alive on <i>Nov 11, 1959</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. W. Elgin</i>		DATE SIGNED <i>Nov. 11, 1959</i>	
PHYSICIAN'S NAME (Type) <i>W. W. Elgin</i>		ADDRESS (Street, city or town, state) <i>Sheppard Pratt Hosp. Towson 4, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-14-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Dryden Ridge Cont</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Saylor</i>		24a. REC'D BY REGISTRAR <i>Nov 16 1959</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>W. W. Elgin</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the health certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12260

Reg. Dist. No.

12285

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ()					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest			c. LENGTH OF STAY IN 1b ()			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lodge Forest (Sparrows Point)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ()				d. STREET ADDRESS 2114 Oak Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Jacob Middle Isaacson Last ()				4. DATE OF DEATH Month Nov Day 2/59 Year 19					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 15 1887		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth Steel Mill ret				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME Isaacso Isaacson				14. MOTHER'S MAIDEN NAME Marie ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ()		16. SOCIAL SECURITY NO. 213-09-3959		17. INFORMANT Address Mrs Martha Isaacson 2114 Oak Road Lodge Forest					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) () DUE TO (c) ()								INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ()									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour () a. m. () p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 11-3-57	
EXAMINER'S NAME (Type) Jack C Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Nov 5/59		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			22d. LOCATION (City, town, or county) (State) Baltimore County		
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave;						24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Kress	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-permit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12286

CERTIFICATE OF DEATH

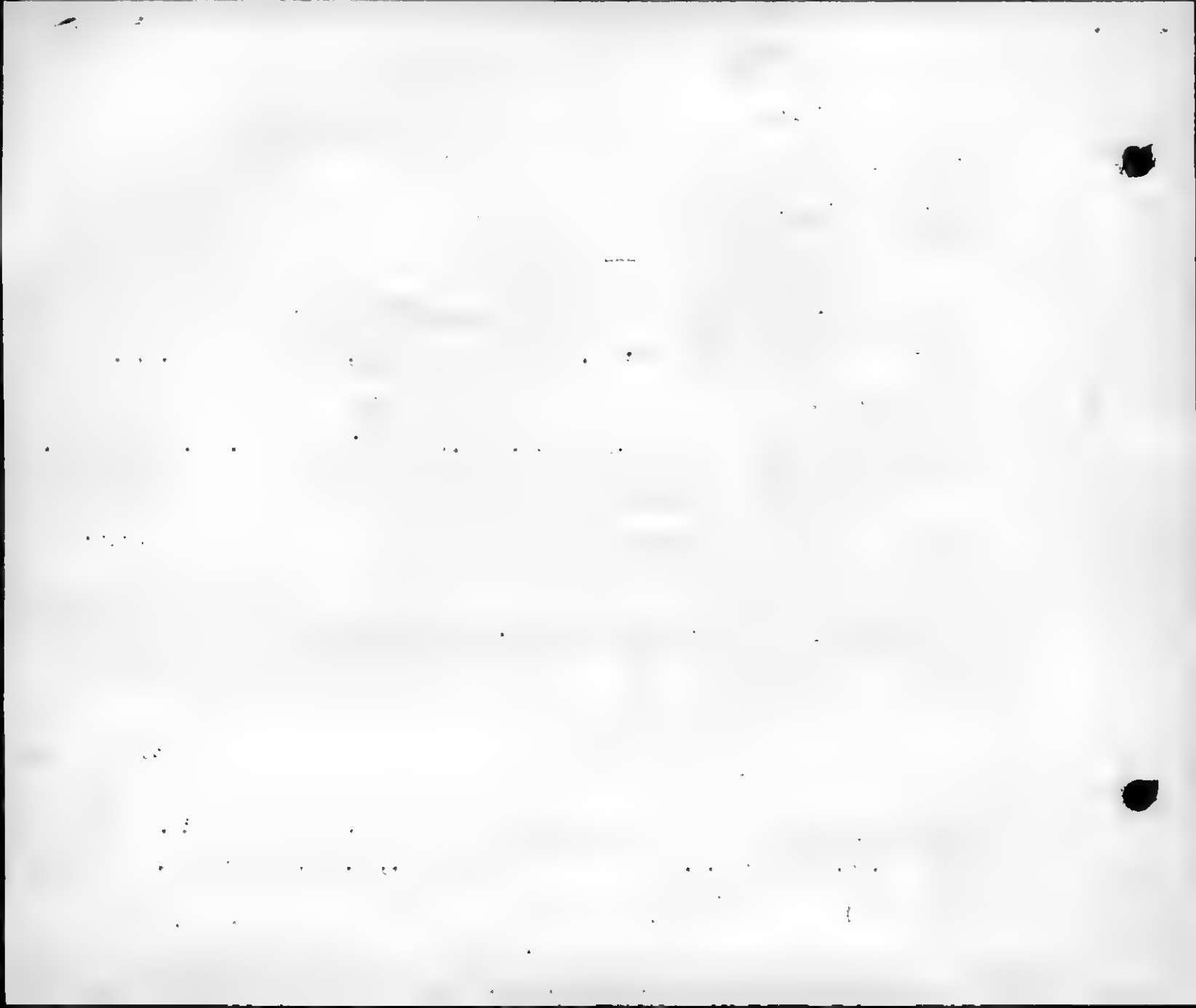
Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS 637 Stirling Street	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIJAH Middle ----- Last JACKSON		4. DATE OF DEATH Month November Day 1 Year 19 59	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1898
9. AGE (In years last birthday) 61 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Drakes Branch, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jackson		14. MOTHER'S MAIDEN NAME Mary Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 217 07 2736	
17. INFORMANT Clin. Rec., VAH Balto 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) CERE BRO-VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS; LEFT MIDDLE CEREBRAL ARTERY THROMBOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 25, 1959 to November 1, 1959 , and that death occurred at 2:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Balto., Md. Ft. Howard Div. 11/1/59 ACTUAL SIGNATURE S. J. MANGUS, M.D. PHYSICIAN'S NAME (Type) VAH Balto., Md. Ft. Howard Div. 11/1/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-5-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		24b. REGISTRAR'S SIGNATURE Calvin E. Harris	
24a. REC'D BY REGISTRAR NOV 2 '59			

ELROY O. WILSON, 2004 ORLEANS ST., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12262

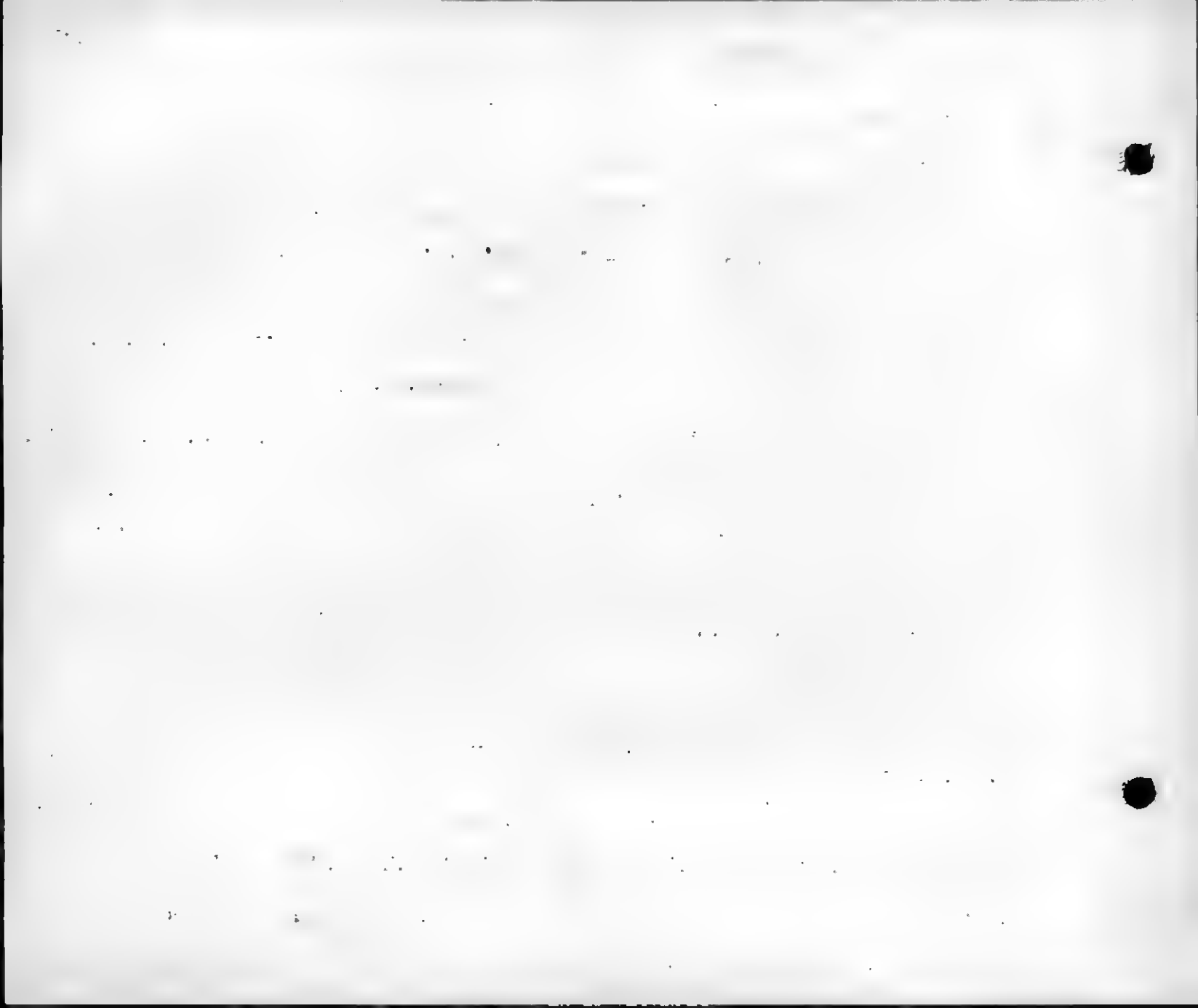
12287

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 48 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore(13) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore(13) d. STREET ADDRESS 2028 Llewellyn Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle --- Last JACKSON				4. DATE OF DEATH Month November Day 19 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1884	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 19 Min 19		11. BIRTHPLACE (State or foreign country) Barnesville, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Barnesville, Virginia	
13. FATHER'S NAME William Jackson				14. MOTHER'S MAIDEN NAME Elie Washington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 217-01-9851		INFORMANT Clinical Records, VAH, Balto. 18, Md., Ft. Howard Div. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE (c) ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of stomach with metastases to the liver, periaortic and peritracheal lymph nodes.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 2, 1959 to November 19, 1959 and that death occurred at 8:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FORT HOWARD DIVISION DATE SIGNED n 11/19/59							
ACTUAL SIGNATURE John W. Crawford M.D.							
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD. FORT HOWARD DIVISION							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Baltimore 17, Md.				24a. REC'D BY REGISTRAR NOV 24 '59		24b. REGISTRAR'S SIGNATURE Charles S. Thompson	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

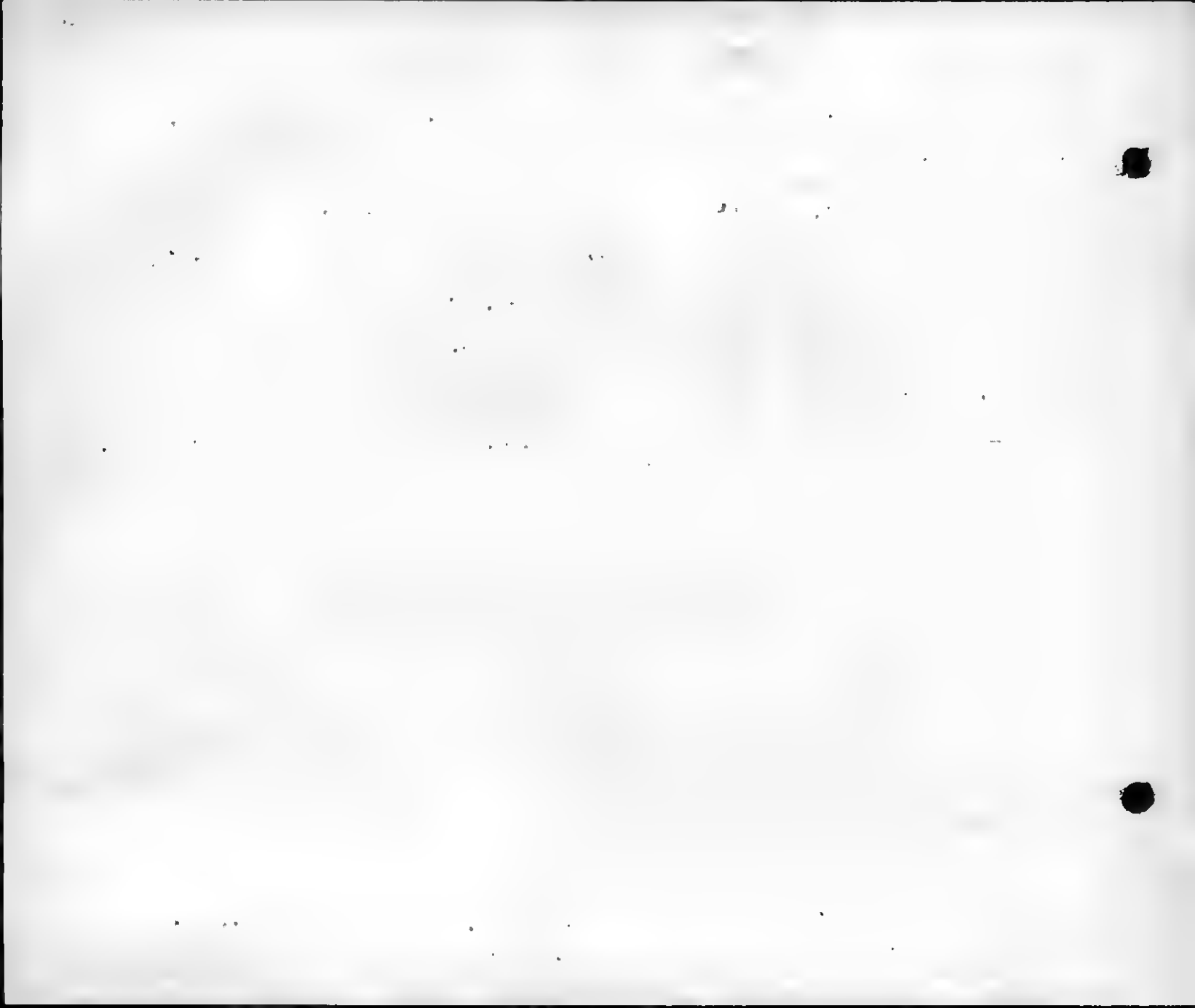


12288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 148 Hopkins Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle GERARD Last JENKINS		4. DATE OF DEATH Month Nov. Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1956
9. AGE (In years lost birthday) 3 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME J. Calvin Jenkins		14. MOTHER'S MAIDEN NAME Sally Brady	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Mr. J. Calvin Jenkins - 148 Hopkins Rd. #12	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphatic leukemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 9-10 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1959 , to Nov. 20, 1959 , that I last saw the deceased alive on Nov. 17, 1959 , and that death occurred at 8:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED University Hospital ACTUAL SIGNATURE Milton S. Sacks M.D. PHYSICIAN'S NAME (Type) MILTON S. SACKS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/23/59	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Adams - Balto.		24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE William S. Thomas



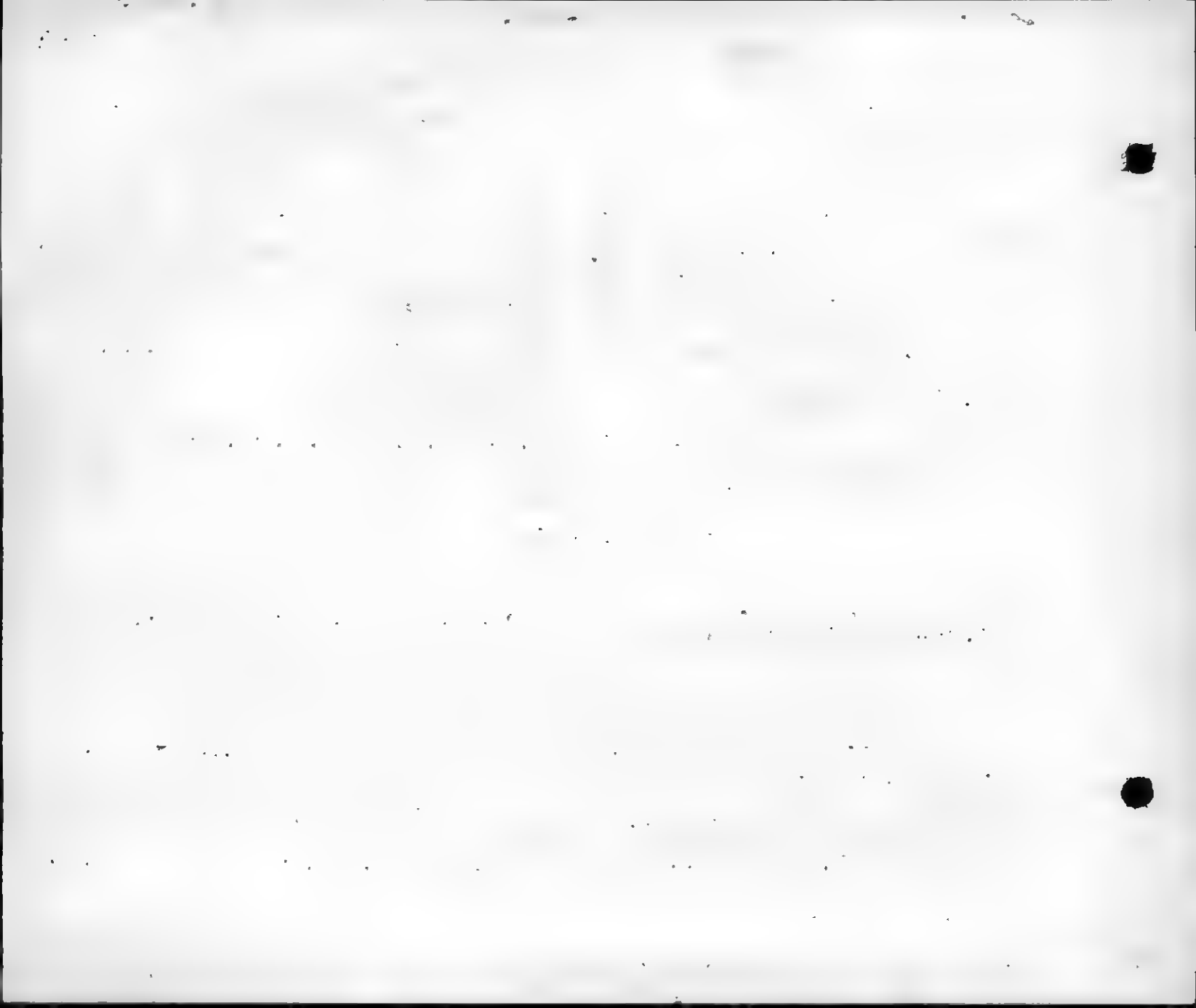
12289

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 110 Prince George Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GROVER Middle P. Last JOHNSON		4. DATE OF DEATH Month November Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18, 1907
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Goldsborough Johnson	
14. MOTHER'S MAIDEN NAME Augusta Robinson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II	
16. SOCIAL SECURITY NO 214-07-7922		17. INFORMANT Clin. Records. VAH, Balto. Md. Ft. Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) CORONARY OCCLUSION DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 Plus Dys.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Old Myocardial Infarction due to Corronary Occlusion. 2. Edema of Lungs. 3. Gout with Multiple Tophi.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that VS attended the deceased from November 11, 1959 to November 25, 1959 and that death occurred at 6:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Crawford</i>		ADDRESS (Street, city or town, state) VAH, BALTIMORE, MD. FT HOWARD DIV	
DATE SIGNED 11/25/59			
PHYSICIAN'S NAME (Type) J OHN W. CRAWFORD, M.D.		VAH, BALTO., MD. FT HOWARD DIV 11/25/59	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/27/59	22c. NAME OF CEMETERY OR CREMATORY Episcopal Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Home, Cambridge, Maryland		24a. REC'D BY REGISTRAR DATE NOV 27 '59	24b. REGISTRAR'S SIGNATURE <i>Charles E. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



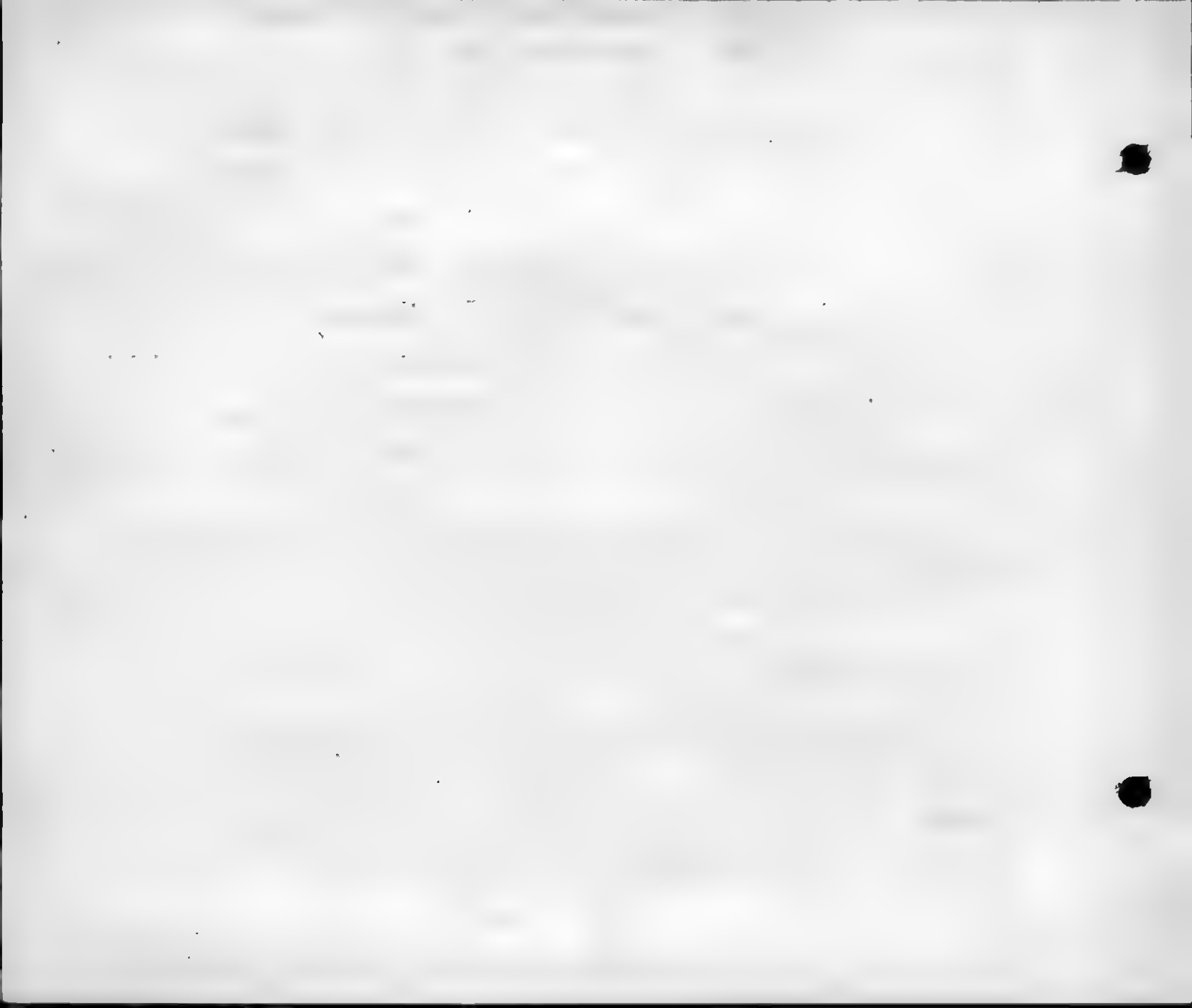
12198

CERTIFICATE OF DEATH

12263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75 Dundalk	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS 8024 Norris Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8024 Norris Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucael Middle Johnson Last Johnson		4. DATE OF DEATH Month November Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April-19th.-1903
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR: Months 56 Days 56 Hours 56 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Essex County Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME James R. Moulton		14. MOTHER'S MAIDEN NAME Fannie Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Horbert Johnson 8024 Norris Road Dundalk Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Stomach DUE TO (c) unknown INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 4/59 to Nov 20/59 , that I last saw the deceased alive on Nov 20/59 , and that death occurred at 12 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Thomas		ADDRESS (Street, city or town, state) 107 N. Main St. Balto 22 Md	
PHYSICIAN'S NAME (Type) J. H. Thomas		DATE SIGNED 11/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetary	22d. LOCATION (City, town, or county) (State) Brooklyn Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elmer Nelson - 1000 Brantley Ave. Baltimore		24a. REG. D. BY REGISTRAR NOV 23 59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

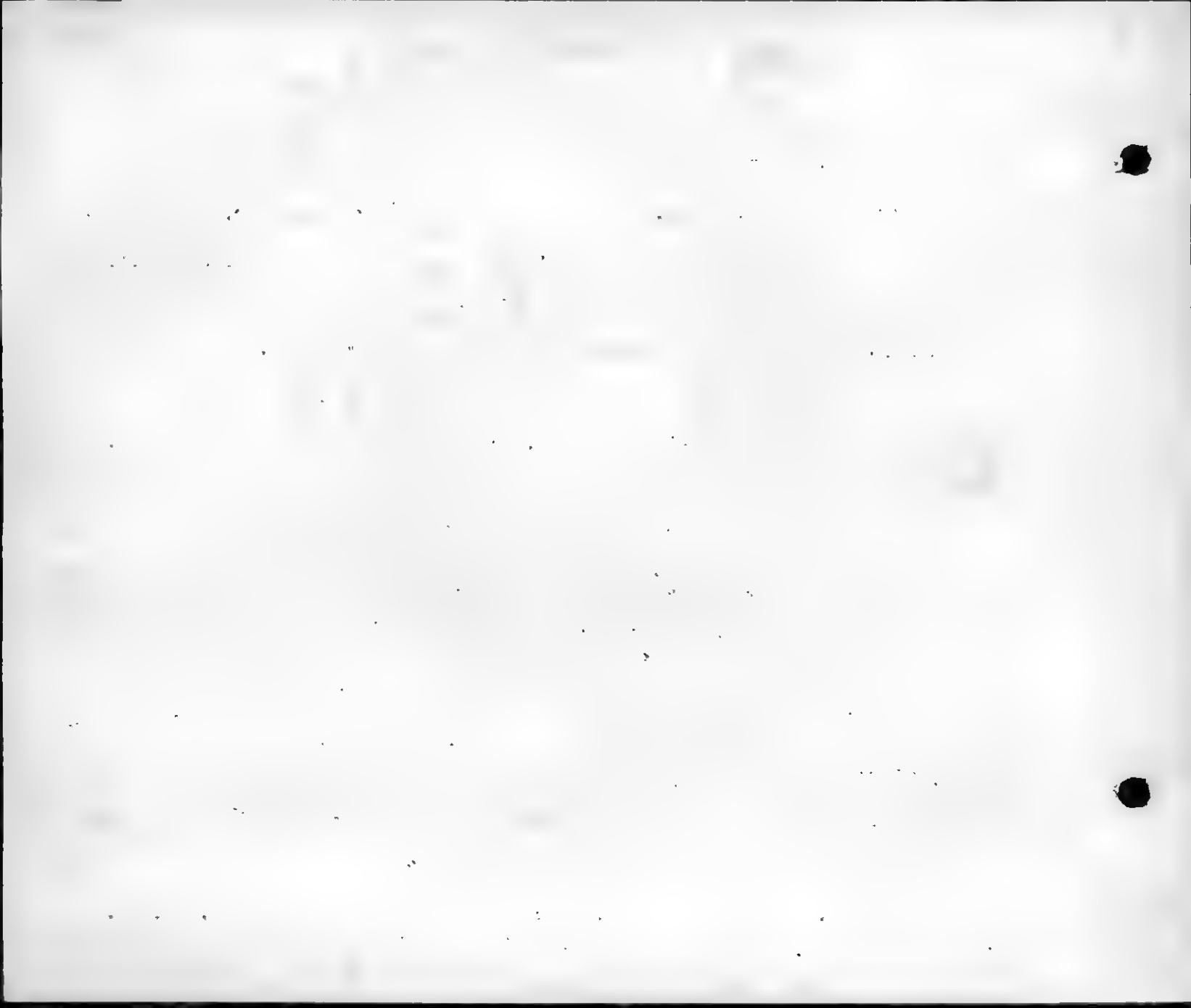
12290

CERTIFICATE OF DEATH

12266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh				c. LENGTH OF STAY IN 1b White Marsh			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 294 Cowenton Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Kahl				4. DATE OF DEATH Month November Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1892		9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min 67	IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Kahl				14. MOTHER'S MAIDEN NAME Mary Furnkas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-6664		INFORMANT Mrs. Theresa Kahl		Address Box 294 Cowenton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4. DUE TO ANGINA PECTORIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO HYPERTENSIVE CARDIOVASC. DIS. (b) 15 yrs. (c) 2 yrs.						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ch. Hypertrophic polyarthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---		20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---		20g. (County) ---		20h. (State) ---	
21. I certify that I attended the deceased from 4/20 , 19 59 , to 11/21 , 19 59 that I last saw the deceased alive on Nov. 19 , 19 59 , and that death occurred at 3:55 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clifford F. Hudson				ADDRESS (Street, city or town, state) FORK, MD.			
DATE SIGNED ---							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Fullerton Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Searchlight Home 7401 Belvid.				24a. REC'D BY REGISTRAR ---		24b. REGISTRAR'S SIGNATURE Clifford F. Hudson	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

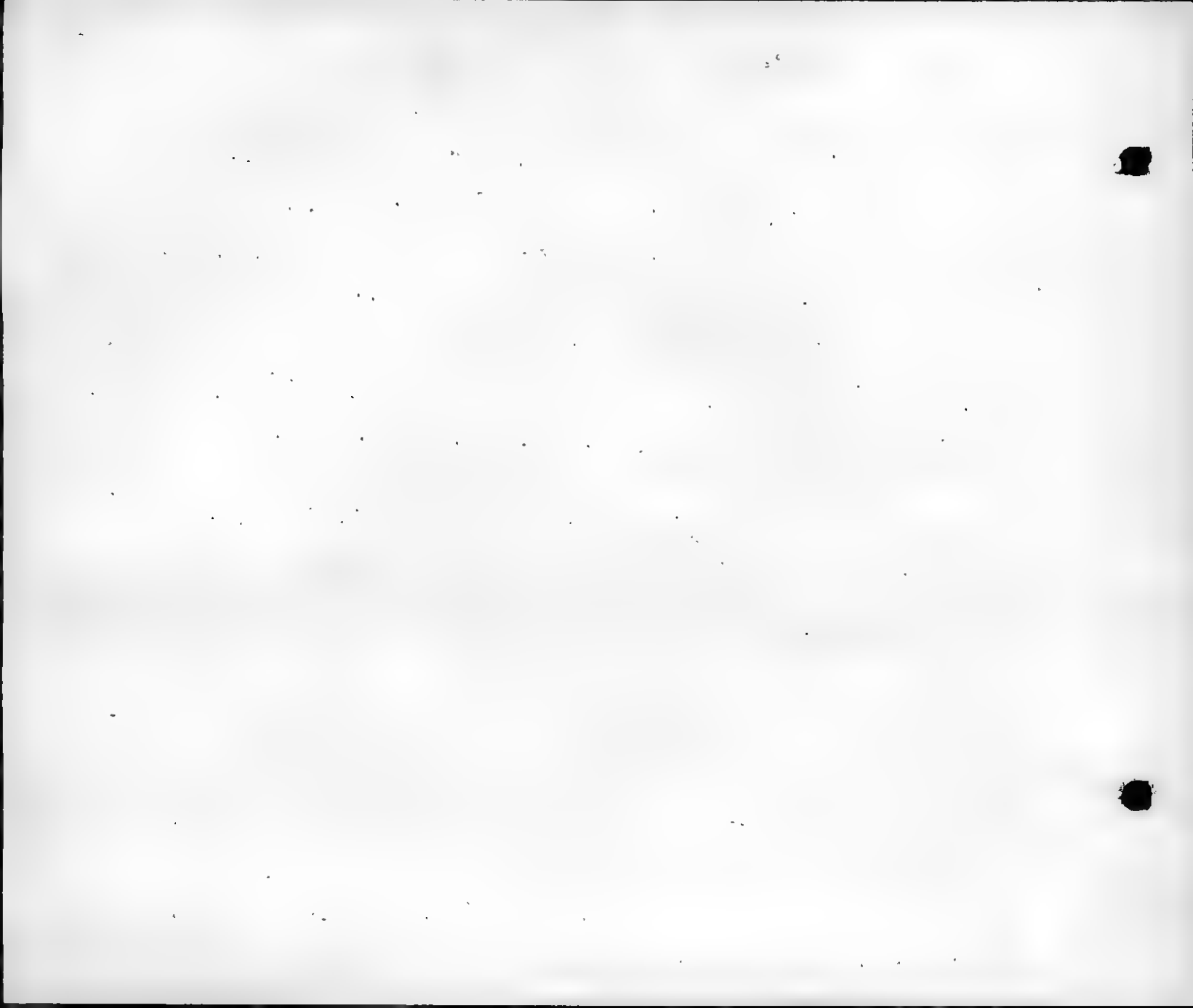
CERTIFICATE OF DEATH

Reg. Dist. No. **12267**

12291

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2810 Taylor Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Parkville</u> d. STREET ADDRESS <u>1 7804 Harford Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>L. Kilchenstein</u> Last _____ 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-12-1900</u> 9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Min. _____				4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1959</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>FRANK C. KILCHENSTEIN</u> 14. MOTHER'S MAIDEN NAME <u>ADELHID E. MACKIN SEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service] 16. SOCIAL SECURITY NO <u>213-26-4340</u> INFORMANT <u>Mary M. Kilchenstein</u> Address <u>same</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) <u>arteriosclerotic hypertension + chronic nephritis</u> DUE TO (c) <u>Previous coronary occlusion 1958</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polomyelitis in infancy</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ a.m. _____ p.m. _____ 19____ 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>1922</u> to <u>Nov. 18, 1959</u> that I last saw the deceased alive on <u>Nov. 18, 1959</u> , and that death occurred at <u>14:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2810 Taylor Ave. Baltimore 14 Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>A. M. Bacon</u> PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 22b. DATE THEREOF <u>11-21-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u> 22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) _____				23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd</u> 24a. REC'D BY REGISTRAR <u>NOV 20 1959</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained in hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12292

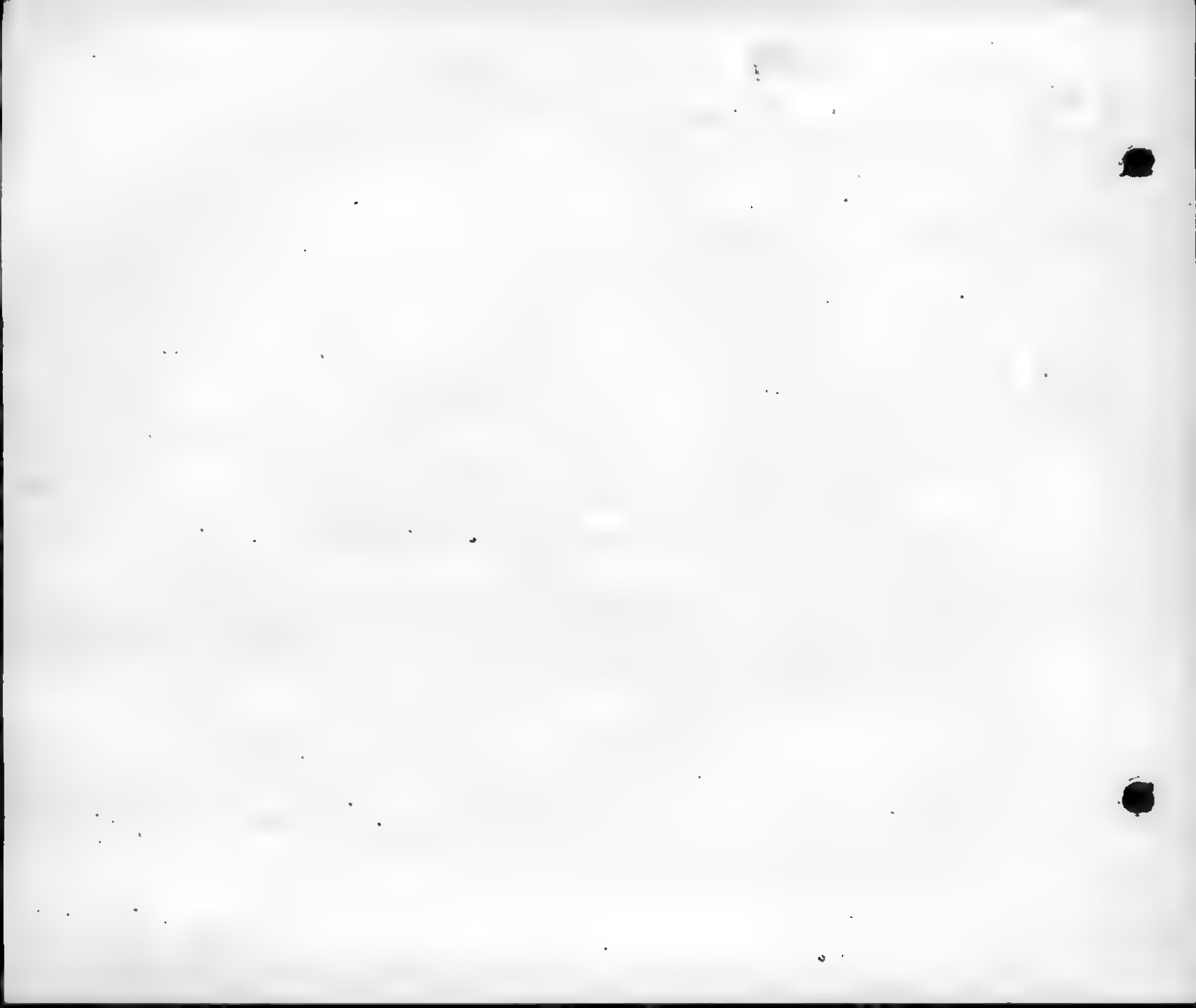
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8827 VICTORY AVE				e. STREET ADDRESS 18827 VICTORY AVE			
3. NAME OF DECEASED (Type or print) PRISCILLA L. KIPP				4. DATE OF DEATH NOV 25 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 8, 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME REUBEN REHRIG				14. MOTHER'S MAIDEN NAME EMELINE RUCH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		INFORMANT Address WINNIE KIPP 8827 VICTORY AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiac Vascular Disease DUE TO (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1959 to Nov 24, 1959 , that I last saw the deceased alive on Nov 24, 1959 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M. Mammaguidum M.D.				ADDRESS (Street, city or town, state) Baltimore Md			
PHYSICIAN'S NAME (Type) M. Mammaguidum				DATE SIGNED 11/25/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV 27, 1959		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) PENNSYLVANIA	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. S. Funeral Home				ADDRESS 7401 BELAIR RD		24a. REC'D BY REGISTRAR NOV 30 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

12293

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12269

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Beltsfordtown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Beltsfordtown</i>	
c. LENGTH OF STAY IN 1b <i>4 years</i>		d. STREET ADDRESS <i>Berryman's Lane</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CARN JACOB KLINGELHOFER</i>		4. DATE OF DEATH <i>Nov. 22 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 4, 1887</i>
9. AGE (In years last birthday) <i>72 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Finisher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wooden Mills</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Adolph Klingelhofen</i>		14. MOTHER'S MAIDEN NAME <i>Mary Wess</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-03-3669</i>	
17. INFORMANT <i>Mrs. Wess Klingelhofen - wife</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>434.1 Congestive Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/22/1959</i> to <i>11/23/1959</i> , that I last saw the deceased alive on <i>11/22/1959</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. E. Martin</i>		ADDRESS (Street, city or town, state) <i>Randallstown, Md.</i>	
DATE SIGNED		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Wm. E. Martin</i>		ADDRESS <i>Randallstown, Md.</i>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>11-25-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Family</i>	22d. LOCATION (City, town, or county) (State) <i>Holbrook, Buld. Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Knight of Hagerstown, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>Nov 30 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12270

Reg. Dist. No.

12294

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek (19)		c. LENGTH OF STAY IN 1b 18 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek (19)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2418 Ketchum Avenue				d. STREET ADDRESS 2418 Ketchum Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle WILTON Last KRAEMER, Sr.				4. DATE OF DEATH Month November Day 15th Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1917	9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months 4 Days 2 Hours 0 Min. 0		10. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Copper & Brass		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles William Kraemer				14. MOTHER'S MAIDEN NAME Laura Masson Kraemer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-09-1410		17. INFORMANT Address Mrs. Erma M. Kraemer same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Cornary Occlusion							INTERVAL BETWEEN ONSET AND DEATH 4
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) As above					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) As above		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/59		22c. NAME OF CEMETERY OR CREMATORY BelAir Memorial Gardens BelAir, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley				24a. REC'D BY REGISTRAR NOV 19 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12271

Reg. Dist. No.

12295

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 MARGARET AVE</u>		e. STREET ADDRESS <u>112 MARGARET AVE</u>	
3. NAME OF DECEASED (Type or print) <u>IRVIN E KROLL</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-08</u>
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANUFACTURER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OSCAR KROLL</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH FAY WICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MRS BARBARA KROLL (SISTER OF DECEASED)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>440.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-6-2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack E. Collins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack E. Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-25-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connolly</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

12272

Reg. Dist. No.

12208

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1043 Maiden Choice Lane		d. STREET ADDRESS 1043 Maiden Choice Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle C Last LaBonte		4. DATE OF DEATH Month November Day 17 Year 1959	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 21, 1901
9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Crib Foreman		10b. KIND OF BUSINESS OR INDUSTRY Western Elec. Co	
11. BIRTHPLACE (State or foreign country) Holyoke, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilbrod LaBonte		14. MOTHER'S MAIDEN NAME Marie L. (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 015-03-7100	
17. INFORMANT Irene B. LaBonte, 1043 Maiden Choice Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion & myocardial infarction DUE TO 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 days DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 13 , 19 59 , to Nov 17 , 19 59 , that I last saw the deceased alive on Nov 15 , 19 59 , and that death occurred at 7 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4001 W. Elmhurst DATE SIGNED 11-17-59 ACTUAL SIGNATURE Karl Pass M.D. Paul J. M. PHYSICIAN'S NAME (Type) T. EARL PASS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-20-59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE NOV 19 59	
24b. REGISTRAR'S SIGNATURE Charles E. K...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12296 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: <u>BALTIMORE COUNTY</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Mercy Villa</u> <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u></u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mercy Villa</u>		STREET ADDRESS (If rural give location) <u>3120 St. Paul St</u>	
3. NAME OF DECEASED: (First) <u>Katherine</u> (Middle) <u>E.</u> (Last) <u>Lacher</u>		4. DATE OF DEATH: (Month) <u>Nov.</u> (Day) <u>13</u> (Year) <u>1959</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>March 4 1915</u>
9. AGE last birthday: <u>44</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>OFFICE MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>INSURANCE</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>GEORGE M. LACHER</u>		14. MOTHER'S MAIDEN NAME: <u>CATHERINE R. HARMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>212-10-4226</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>REV. E. L. LACHER P.O. Box 6936 BALD. 16</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of Ovary</u>		<u>6 months</u>
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: <u>June 10 1959</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION: <u>Cx of Ovary & metastases.</u>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>59</u> , to <u>Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>59</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.		
SIGNATURE <u>Leo A. Grace Jr MD</u> (Degree or title)		DATE SIGNED <u>11/23/59</u>
ADDRESS <u>1039 St. Paul St Baltimore Md.</u>		
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>11-25-59</u>	NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>
LOCATION (City, town, or county) <u>BALTO.</u>	(State) <u>MD.</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>Arthur A. Hanna</u>	24. FUNERAL DIRECTOR <u>N.W. JENKINS & SONS Co.</u>
		ADDRESS <u>4905 YORK RD.</u>
NOV 24 '59		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

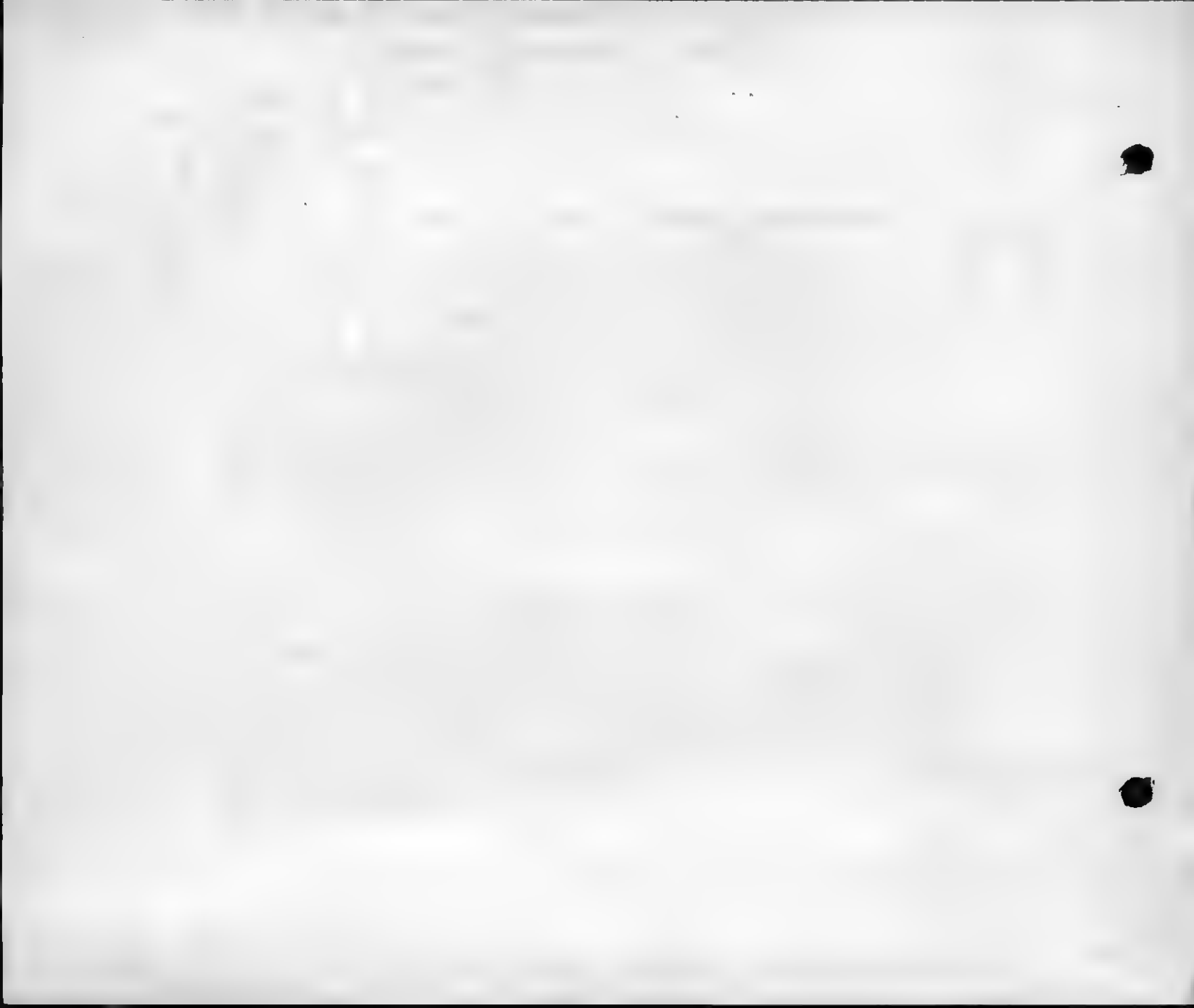
12297 CERTIFICATE OF DEATH

12274

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VILLA JULIE		d. STREET ADDRESS VILLA JULIE - VALLEY RD.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF SISTER MARIE CHAIRE (Type or print) First Middle Last (ELIZABETHE, LEAHY)		4. DATE OF DEATH Month NOV Day 18 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 12, 1874
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. EDUCATOR		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	11. BIRTHPLACE (State or foreign country) MASS.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME WILLIAM LEAHY	
14. MOTHER'S MAIDEN NAME MARY HARRINGTON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Sister Mary. Patrick - Villa Julie	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Renal Vascular disease. DUE TO Age. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Age. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 14 , 19 57 , to Nov 18 , 19 59 , that I last saw the deceased alive on Nov 14 , 19 59 , and that death occurred at 2 P M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Harold H. Burns M.D. 115 C City - N 11-18-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Harold H. Burns			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-59	22c. NAME OF CEMETERY OR CREMATORY Trinity Convalescent Cemetery	22d. LOCATION (City, town, or county) (State) Frederick Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home - Catonsville, Ind.		24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1112 Sulfur Spring Rd</u>				d. STREET ADDRESS <u>1112 Sulfur Spring Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Levi</u> Middle Last				4. DATE OF DEATH <u>Nov</u> Month <u>29</u> Day <u>1959</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June-1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>? Levi</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Whittington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Maek Brown</u> Address <u>1112 Sulfur Spring Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute Cardiac failure</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Vascular disease</u></p> <p>DUE TO (c) _____</p> </div> <div style="width: 45%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) <u>Geo. S. M. KIEFFER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Frances A. Hemsley</u> ADDRESS <u>573 W. Biddle St</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hems</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

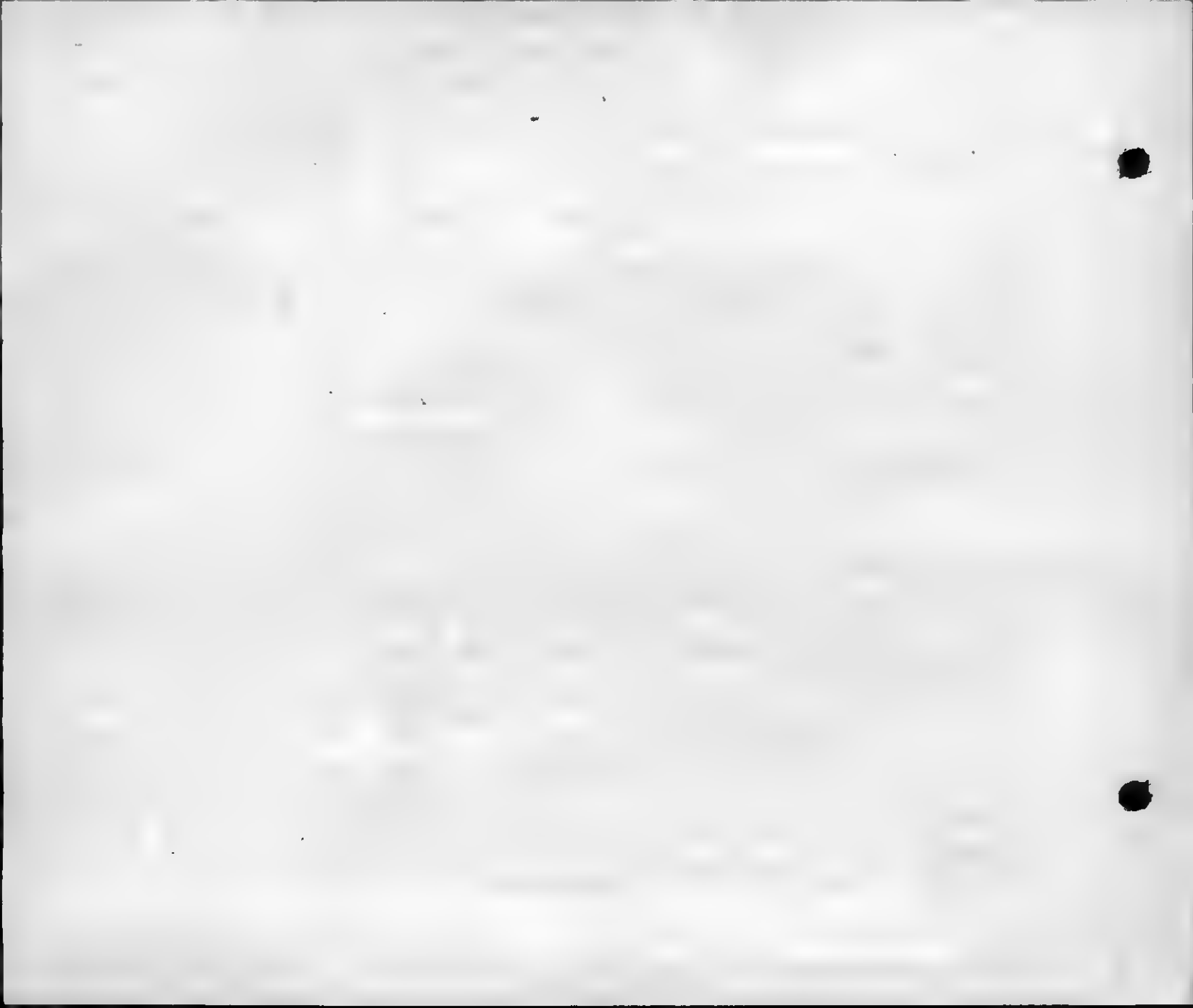
12299

CERTIFICATE OF DEATH

Reg. Dist. No.

12276

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESACO PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE #6.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 501 PATAPSCO AVE				e. STREET ADDRESS 501 PATAPSCO AVE			
3. NAME OF DECEASED (Type or print) First LESTER Middle E. Last LINTON				4. DATE OF DEATH Month NOVEMBER Day 5 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 4, 1912	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRCCER
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRCCER			10b. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ARTHUR LINTON				14. MOTHER'S MAIDEN NAME AMELIA DILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO ---		17. INFORMANT ELIZABETH M. LINTON		Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE (c) HYPERTENSION						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4.29.55 19 55 to 11.5 19 59 , that I last saw the deceased alive on 11.5.59 19 59 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John L. Orth M.D.				ADDRESS (Street, city or town, state) Rosedale Medical Group DATE SIGNED 8014 Philadelphia Rd.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-9-59		22c. NAME OF CEMETERY OR CREMATORY WESTERN CEM.		22d. LOCATION (City, town, or county) (State) EDMONDSON AVE. BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Miller				ADDRESS 901 S CONKLING ST. BALTO. 24. MD.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
				24b. REGISTRAR'S SIGNATURE Calvin S. Thum			



12300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4yr3mth19dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 3509 Madison Place	
3. NAME OF DECEASED (Type or print) Elma Basnight Lupton		4. DATE OF DEATH Month 11 Day 11 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular accident DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks 1 month several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome - assoc. with senile brain disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 9, 1959, to Nov. 11, 1959 , that I last saw the deceased alive on Nov 11, 1959 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radawski M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11/11/59	
PHYSICIAN'S NAME (Type) BRUNO RADAWSKI		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/12/59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Wash., D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Alfred Heine		ADDRESS 1000 16th St. N.W.	
24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Clara S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12278

12301

1. PLACE OF DEATH a. COUNTY BAKERS Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Oakway Rd		e. STREET ADDRESS 14 Oakway Rd.	
3. NAME OF DECEASED (Type or print) BERTUS LYMBERG		4. DATE OF DEATH Nov. 20. 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
11. BIRTHPLACE (State or foreign country) Holland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roelof Lymborg		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-0769	
17. INFORMANT Hazel E. Lymborg		Address 14 Oakway Rd. Timonium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 973.3 Carbon Monoxide Poisoning Sudden. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/59	
22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens		22d. LOCATION (City, town, or county) (State) Timonium, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md.		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Philip M. Lynch		4. DATE OF DEATH Month Day Year November 19, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		10b. KIND OF BUSINESS OR INDUSTRY Funeral Director Baltimore, Md.	11. BIRTHPLACE (State or foreign country) USA
13. FATHER'S NAME James P. Lynch		14. MOTHER'S MAIDEN NAME Mary Gaierty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-10-7682	
17. INFORMANT Mrs. Mary O'Connor Lynch		Address (Same) 3003 Cresmont	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of prostate to brain 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca of prostate DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 weeks Dec 1959	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 29, 1957 to Nov 18, 1959 , that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 7:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Michael F. Ramey M.D.		ADDRESS (Street, city or town, state) 705 Medical Center Bldg Baltimore, Md.	
PHYSICIAN'S NAME (Type) C. Michael F. Ramey		DATE SIGNED Nov 18, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co. Balto. 12, Md.		24a. REC'D BY REGISTRAR NOV 23 59	24b. REGISTRAR'S SIGNATURE C. Michael F. Ramey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12303

CERTIFICATE OF DEATH

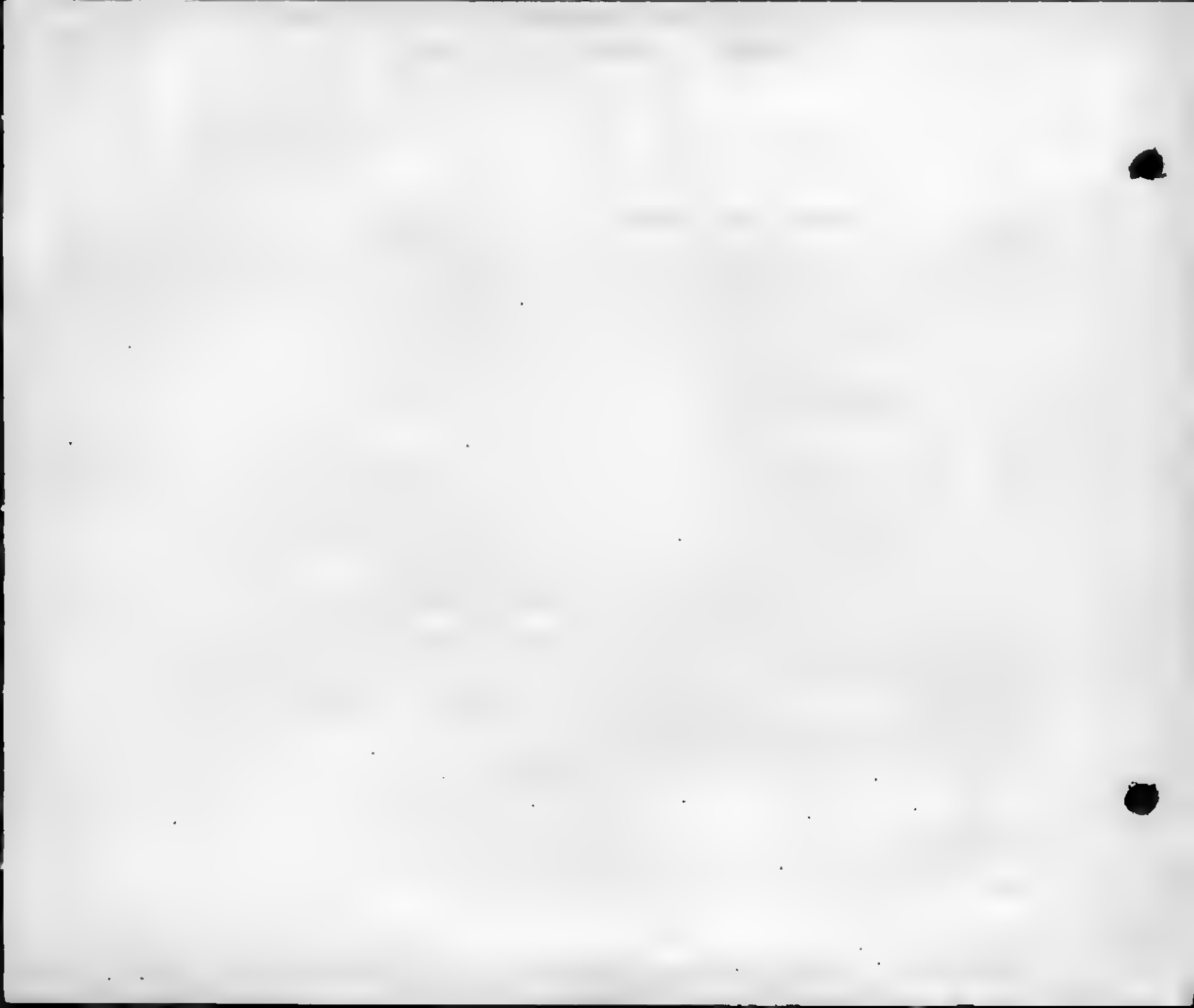
Reg. Dist. No.

12280

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Adeltrudis Manz		4. DATE OF DEATH Month Day Year November 5 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1874
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Religious	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Manz		14. MOTHER'S MAIDEN NAME Walburga Strobel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Renal Vascular Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 53 , to Nov. , 19 59 , that I last saw the deceased alive on Nov 7 , 19 59 , and that death occurred at 9:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 7501 York Road Towson, 4, Md. 11/1/59	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-7-59	22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.	22d. LOCATION (City, town, or county) (State) NOTCHCLIFF NR TOWSON, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jester		ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.	
24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12304

CERTIFICATE OF DEATH

12281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rural				c. LENGTH OF STAY IN 1b Baltimore-Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7908 Springway Road				d. STREET ADDRESS 7908 Springway Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HENRY Middle OLIVER Last MARTEL				4. DATE OF DEATH Nov. 21, 1959 Month Nov. Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Martel				14. MOTHER'S MAIDEN NAME Virginia Marcou			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 002-03-3659		17. INFORMANT Address Josephine H. Martel-7908 Springway Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS DUE TO ARTERIOSCLEROSIS, General Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs (c) 2 yrs							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) NONE					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	Month 11	Day 21	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6210 York Rd	20f. (City or town) Baltimore	(County) Baltimore (State) Md.
21. I certify that I attended the deceased from Feb. 3, 1959 to Nov. 21, 1959 , that I last saw the deceased alive on Nov. 20, 1959 , and that death occurred at 2:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A.S. Chalant				DATE SIGNED Nov. 21, 1959			
PHYSICIAN'S NAME (Type) Dr. A.S. CHALANT				ADDRESS (Street, city or town, state) Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORY Hanover-New Hampshire		22d. LOCATION (City, town, or county) (State) Hanover-New Hampshire			
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE William S. Evans



12305

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO/HIGHLANDS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO/HIGHLANDS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>3010 ALABAMA AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ADOLPH</u> First <u>MARTIN</u> Middle <u>7</u> Last		4. DATE OF DEATH <u>11-7-59</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8 1885</u> 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOLDS MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GLASS CO</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO CITY</u>
13. FATHER'S NAME <u>LEONARD MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>AUGUSTATTEMME</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>174-03-2211</u>	
17. INFORMANT <u>MRS ANNAGETZ</u>		Address <u>3010 ALABAMA AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Arteriosclerotic C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V.D.</u> (c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3.1.59</u> , 19 <u>59</u> , to <u>11.7.59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11.6.59</u> , 19 <u>59</u> , and that death occurred at <u>1:05 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Nathan Racusin</u>		ADDRESS (Street, city or town, state) <u>206 S. Gilmore st.</u> DATE SIGNED <u>11.7.59</u>	
PHYSICIAN'S NAME (Type) <u>NATHAN RACUSIN</u>		<u>134 1th. 23 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>	22d. LOCATION (City, town, or county) (State) <u>EDMONDSON AVE CITY 23</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo H Leimbach</u>		ADDRESS <u>525 W. LYNDHURST ST</u>	
24a. REC'D BY REGISTRAR <u>DATE NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles R. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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49

1

12306

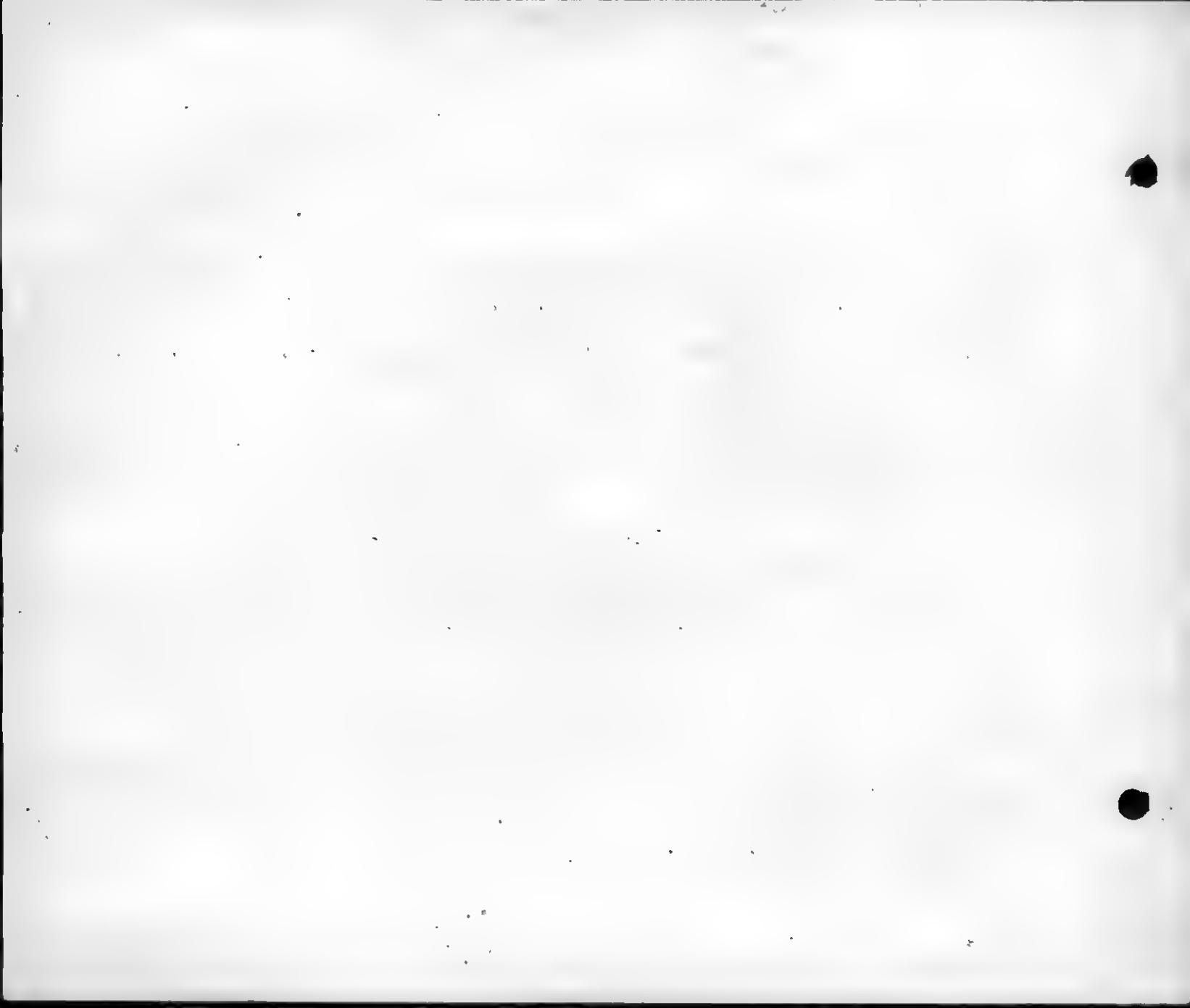
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7, Md.</u>	
		f. STREET ADDRESS <u>3800 Arbutus Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kenneth Donald McAllister</u>		4. DATE OF DEATH Month Day Year <u>Nov 14, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>	
11. BIRTHPLACE (State or foreign country) <u>Seattle, Wash.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Claire McAllister</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>531-05-9522</u>	
INFORMANT <u>Mrs. Helen M. McAllister, 3800 Arbutus Ave.</u>		Address <u>Baltimore 7, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Artery Disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Spring</u> , 19 <u>56</u> , to <u>Nov 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>59</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ronin D. Hansen</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>713 Highland Hall Rd Pikesville</u> <u>9/16/59</u>	
PHYSICIAN'S NAME (Type) <u>Louis DALMAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov. 18, 1959</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24. REC'D BY REGISTRAR DATE <u>NOV 18 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Christina S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12284

12199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 DUNDALK</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>46 TOWNSHIP ROAD</u>				d. STREET ADDRESS <u>46 TOWNSHIP ROAD</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>M</u> Last <u>CLAFFREY</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 16, 1909</u>		9. AGE (in years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>PENN.</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Edward</u>				14. MOTHER'S MAIDEN NAME <u>MARY FITZMAURICE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war as dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARY McCLAFFREY, 46 Township Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>							
DUE TO (b) <u>A-S-C-U Disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>NOV. 14, '59</u>		<u>NEW CATHEDRAL CEM.</u>		<u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly & Zeller Inc., 403 S. Wolfe St.</u>				24a. REC'D BY REGISTRAR <u>NOV 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

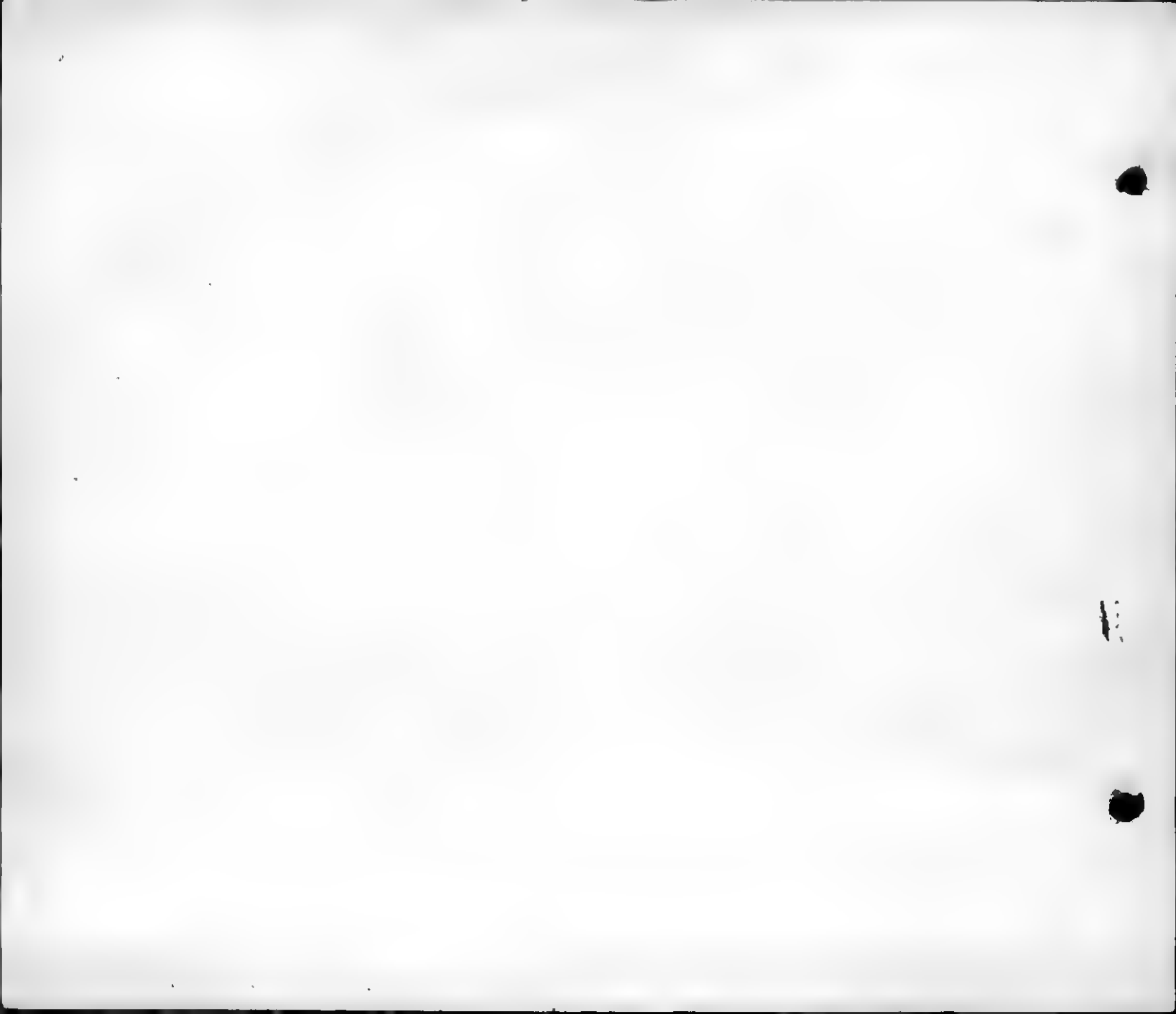
12285

12307

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essex</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>339 Worton Road</u>				STREET ADDRESS (If rural give location) <u>339 Worton Road</u>			
3. NAME OF DECEASED: (Type or Print) <u>Daisy Ida McCann</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Nov. 12, 1959</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>8/26/1885</u>	
9. AGE last birthday: <u>74</u> yrs.		10. MONTHS: <u>12</u>		11. DAYS: <u>19</u>		12. HOURS: <u>19</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME: <u>Sidney Dryden</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Dryden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mrs. Mary McC. Messenger, 339 Worton Rd.</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>420.1 CORONARY OCCLUSION</u>				<u>1 DAY</u>			
ANTECEDENT CAUSE (B) <u>ARTERIO-SCLEROTIC CARDIO-VASC. DISEASE</u>				<u>10 YRS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 12, 1959</u> , to <u>Nov 12, 1959</u> , that I last saw the deceased alive on <u>Nov 12, 1959</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter S. Semensoff</u>				ADDRESS <u>M. D. 2108 CRENSHAW Rd. Baltimore 20, Md.</u>		DATE SIGNED <u>11/12/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/14/59</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>NOV 16 '59</u>		REGISTRAR'S SIGNATURE <u>William S. Semensoff</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc., 1217 St. Paul St., Balt. 2, Md.</u>		ADDRESS	



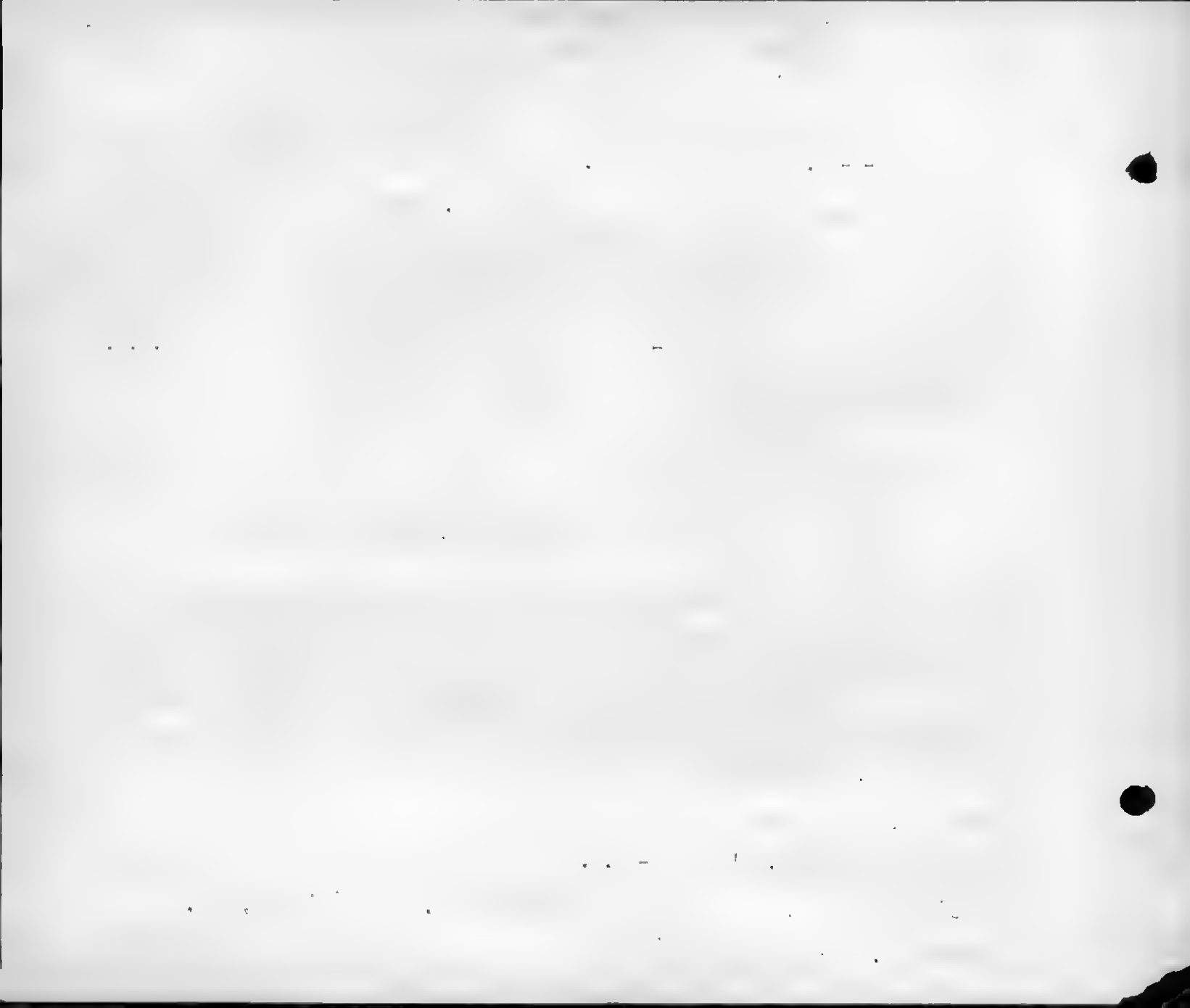
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12308
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson-4-Md.		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		e. STREET ADDRESS 204 E. Main Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last McHugh		4. DATE OF DEATH Month 11 Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/1873
9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Donegan		14. MOTHER'S MAIDEN NAME Mary Fitzgerald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO None	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4 1 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 16-yr (c)		INTERVAL BETWEEN ONSET AND DEATH 16-yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19 56 to November 19 59 that I last saw the deceased alive on November 4 19 59 and that death occurred at 5:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Rd Towson #4 Md DATE SIGNED 4/6/59 ACTUAL SIGNATURE Charles F. O'Donnell M.D. PHYSICIAN'S NAME (Type) Charles F. O'Donnell- M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Rd		24a. REC'D BY REGISTRAR NOV 9 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



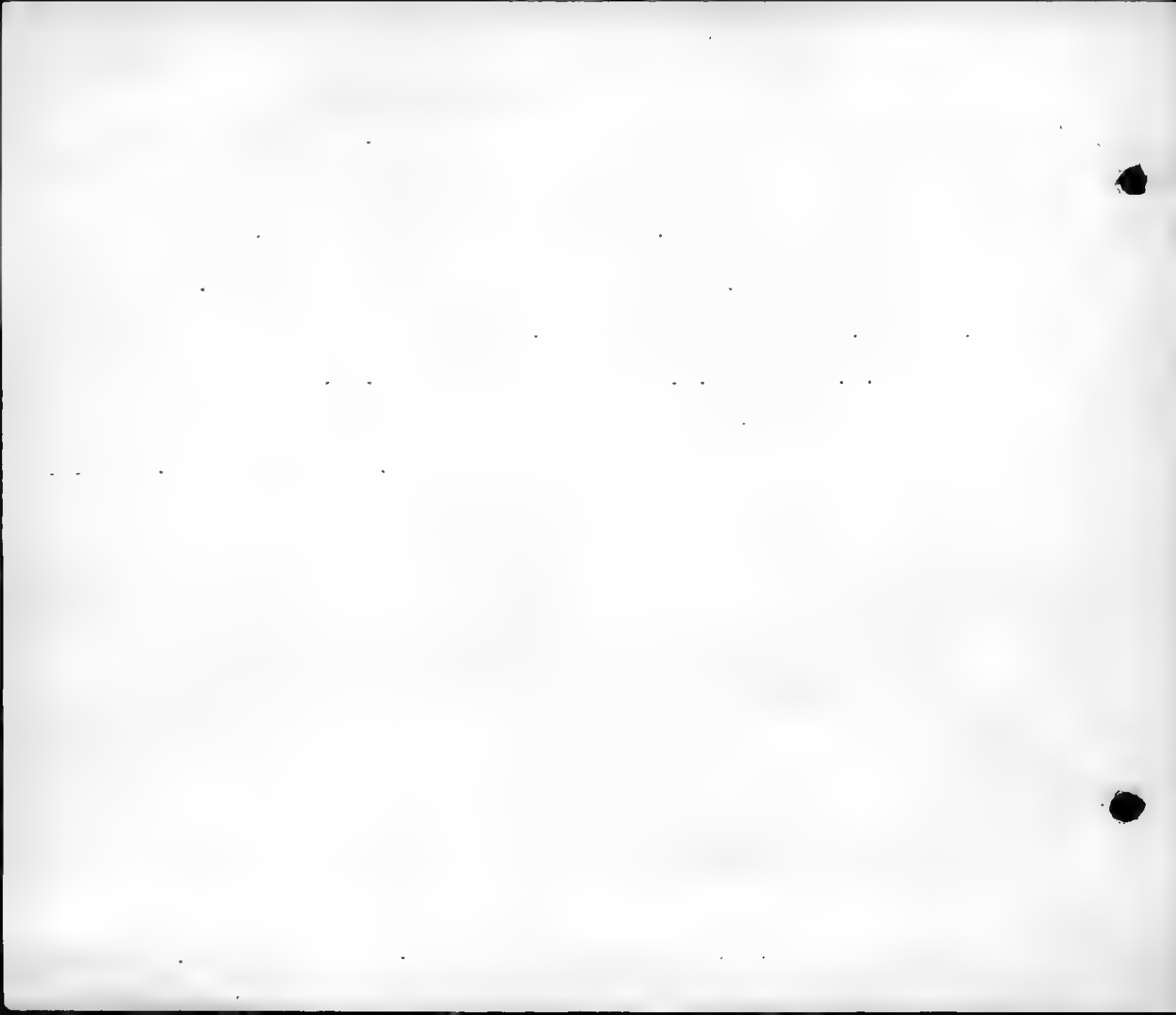
12309

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>12</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bowleys Qtrs</u>		LENGTH OF STAY (In this place) <u>7 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bowleys Qtrs</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>255 Bay Dr.</u>				STREET ADDRESS (If rural give location) <u>255 Bay Dr.</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Edna</u>		(Middle) <u>F.</u>		(Last) <u>Meil</u>		DATE OF DEATH: <u>Nov. 24, 1959</u>	
5. SEX: <u>F.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Aug. 10, 1893</u>	
9. AGE last birthday: <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>O.H.</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Joseph C. Fowler</u>		14. MOTHER'S MAIDEN NAME: <u>Charlotte Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-2901</u>		17. INFORMANT & ADDRESS: <u>William A. Meil, 255 Bay Dr. Balto. 20</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Gall Bladder, metastatic</u>						<u>5 mo.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19. DATE OF OPERATION: <u>Sept 1959</u> 19. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of gall bladder</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 195 <u>8</u> , to <u>Nov 24, 1959</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>59</u> , and that death occurred at <u>8 A M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Louis Semenov</u>		ADDRESS <u>M. D. 2108 Combs Rd, Balto. 20 Md</u>		DATE SIGNED <u>11/24/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombment</u>		DATE THEREOF <u>Nov. 27, '59</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemt.</u>		LOCATION (City, town, or county) <u>Woodlawn Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>NOV 27 '59</u>		REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>		24. FUNERAL DIRECTOR <u>Witzke Funeral Dir.</u>		ADDRESS <u>4101 Edmonson</u>	

MARGIN RESERVED FOR BINDING



12200

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3018 Dunleer Road		d. STREET ADDRESS 3018 Dunleer Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle EARL Last MEREDITH		4. DATE OF DEATH Month November Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1894
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James E. Meredith		14. MOTHER'S MAIDEN NAME ? Meredith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Madeline Meredith 3018 Dunleer Road.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion DUE TO 4x100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-U - Disease + Pulmonary DUE TO Emphysema (c) 54K		INTERVAL BETWEEN ONSET AND DEATH 5 M. 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April - 1954 to Nov. 17, 1959 , that I last saw the deceased alive on Nov 6, 1959 , and that death occurred at 10:55 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE M.B. Davis M.D. 6800 MORNIXTON ROAD		DUNDALK - MD 11/20/59	
PHYSICIAN'S NAME (Type) M-B. Davis MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/23/59	22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge	22d. LOCATION (City, town, or county) (State) Dorsey, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE NOV 27 '59	
		24b. REGISTRAR'S SIGNATURE Carston S. Kneiss	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



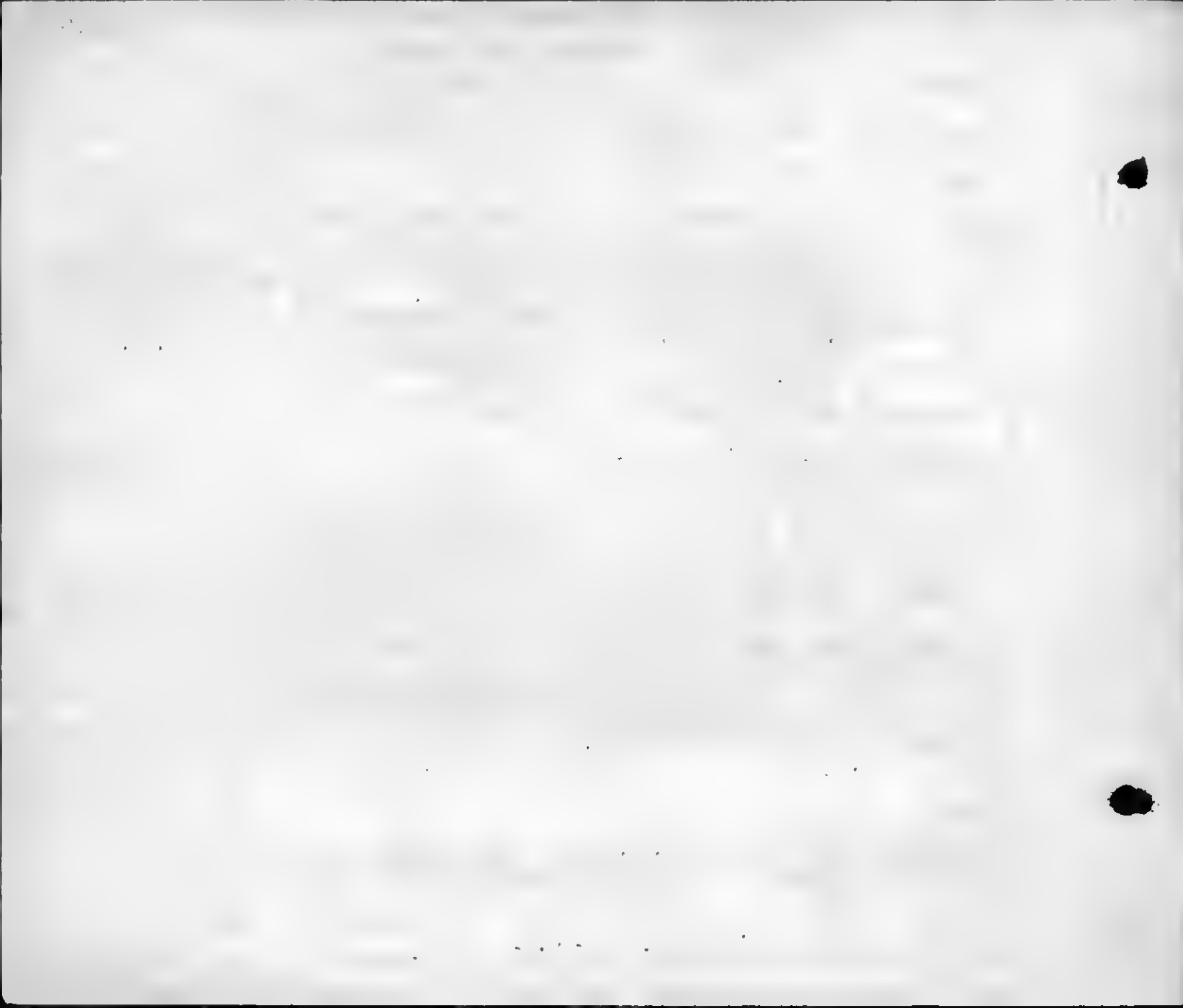
12310

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Mario Last Messina		4. DATE OF DEATH Month November Day 10 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 12 Days 24 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Cutter		10b. KIND OF BUSINESS OR INDUSTRY Marble	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Salvatore Messina		14. MOTHER'S MAIDEN NAME Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 102-09-4456	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular accident DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 28 , 19 59 , to Nov. 10 , 19 59 , that I last saw the deceased alive on Nov. 10 , 19 59 , and that death occurred at 10:20a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-10-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/13/59	22c. NAME OF CEMETERY OR CREMATORY Forest Lincoln Cem.	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home Mt. Rainier		24a. REC'D BY REGISTRAR Nov 16 1959	
ADDRESS Inc. Md.		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12311

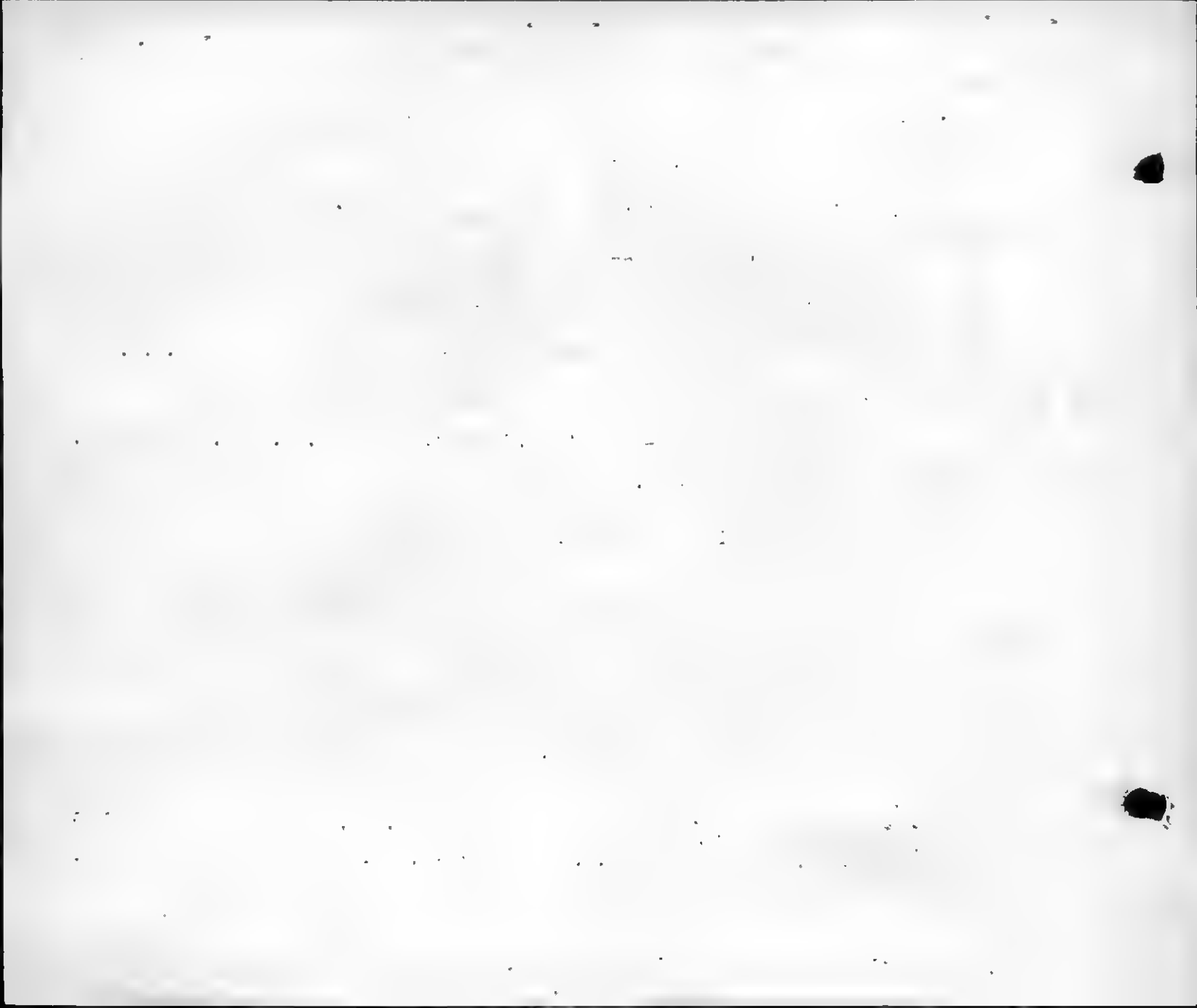
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE Maryland		b. COUNTY 3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 87 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2310 Mayfield Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KAROL		Middle ---		Last MIECZKOWSKI		4. DATE OF DEATH Month November	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1894	
9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0		12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sausage Maker		10b. KIND OF BUSINESS OR INDUSTRY Meat Company		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Mieczkowski				14. MOTHER'S MAIDEN NAME Rosalie (Maiden Name Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-07-9958		17. INFORMANT Clin. Records, VAH, Balto. Md., Ft. Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 27, 1959 to November 22, 1959 , and that death occurred at 2:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. MD. - FT HOWARD DIVISION DATE SIGNED 11/22/59							
ACTUAL SIGNATURE <i>George C. McElvick</i>		PHYSICIAN'S NAME (Type) GEORGE C. MC ELVICK, M.D. VAH, BALTO. MD. - FT HOWARD DIVISION					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WM. FTALKOWSKI FUNERAL HOME, 2007 Eastern Ave.				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thane</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

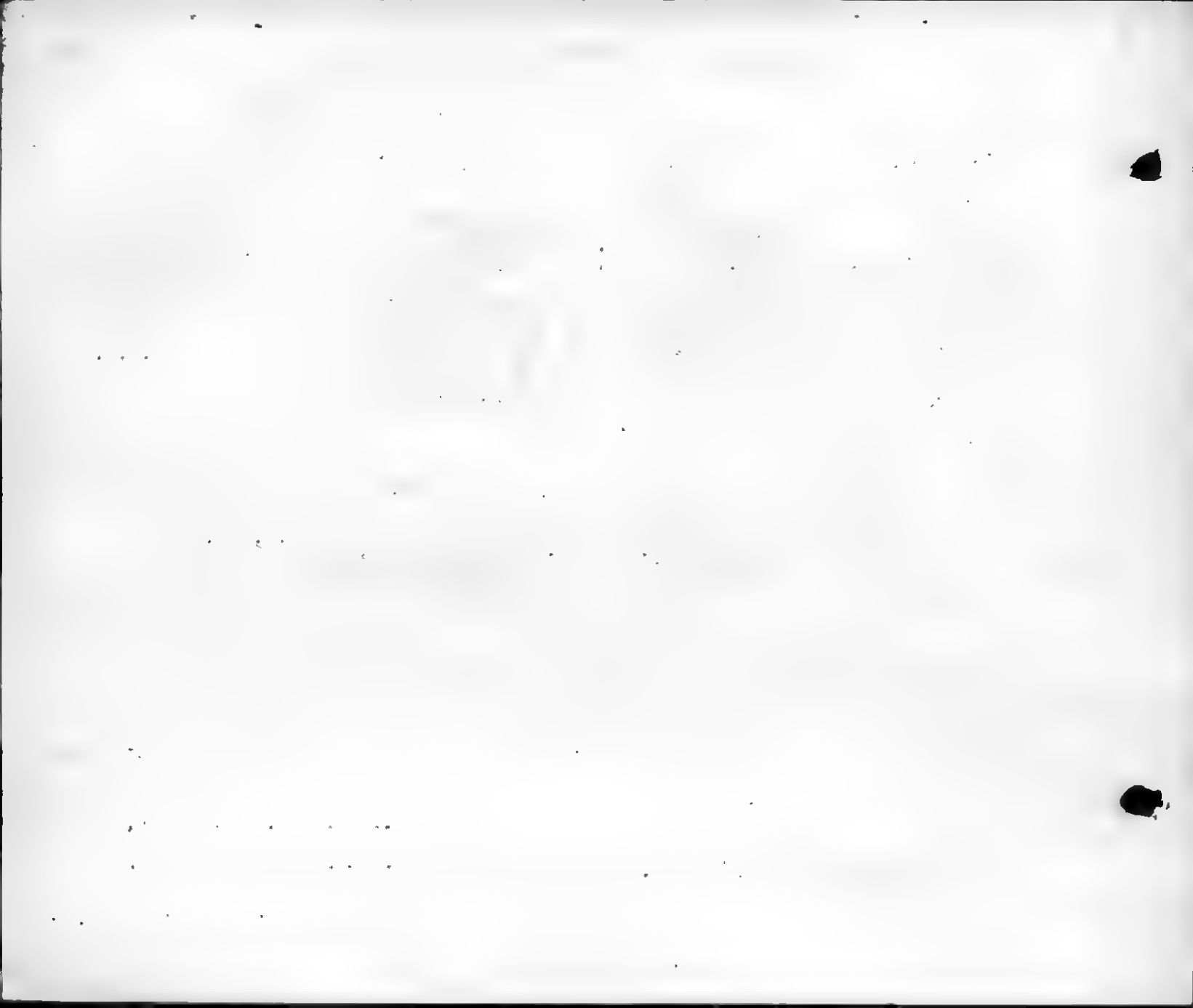
Reg. Dist. No. 12291

12312

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE MARYLAND b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD C. MIELKE Served as: EDWIN		4. DATE OF DEATH Month NOVEMBER Day 27 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 19, 1887
9. AGE (In years lost birthday) 72 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST MIELKE		14. MOTHER'S MAIDEN NAME BERTHA CHALK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. unk.	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE STOMACH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC ADENOCARCINOMA TO PERIGAESTRIC, PERI-PANCREATIC, PERIAORTIC LYMPH NODES, LIVER, LUNGS (c) & ADRENALS ---- JAUNDICE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from November 16, 1959 to November 27, 1959 , that cause of death stated above, and that death occurred at 3:36 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Harold R. Johnson M.D. VAH Balto., Md., Ft. Howard Div. 11/28/59 PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, MD. VAH Balto., Md., Ft. Howard Div. 11/28/59 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 11-30-59 22c. NAME OF CEMETERY OR CREMATORY CREAGERSTOWN CEMETERY 22d. LOCATION (City, town, or county) (State) CREAGERSTOWN, FREDERICK CO., MD. 23. FUNERAL DIRECTOR'S SIGNATURE WEER & HAIGHT, Sykesville, Maryland 24a. REC'D BY REGISTRAR DEC 1 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12292

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sunnybrook c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunnybrook d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RACHEL First Middle Last 4. DATE OF DEATH November 3, 1959 Month Day Year		5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH MILLER WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 55 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr. EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11.30.59 22c. NAME OF CEMETERY OR CREMATORY Calverton 22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR ADDRESS		24a. REC'D BY REGISTRAR DEC 1 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



12314

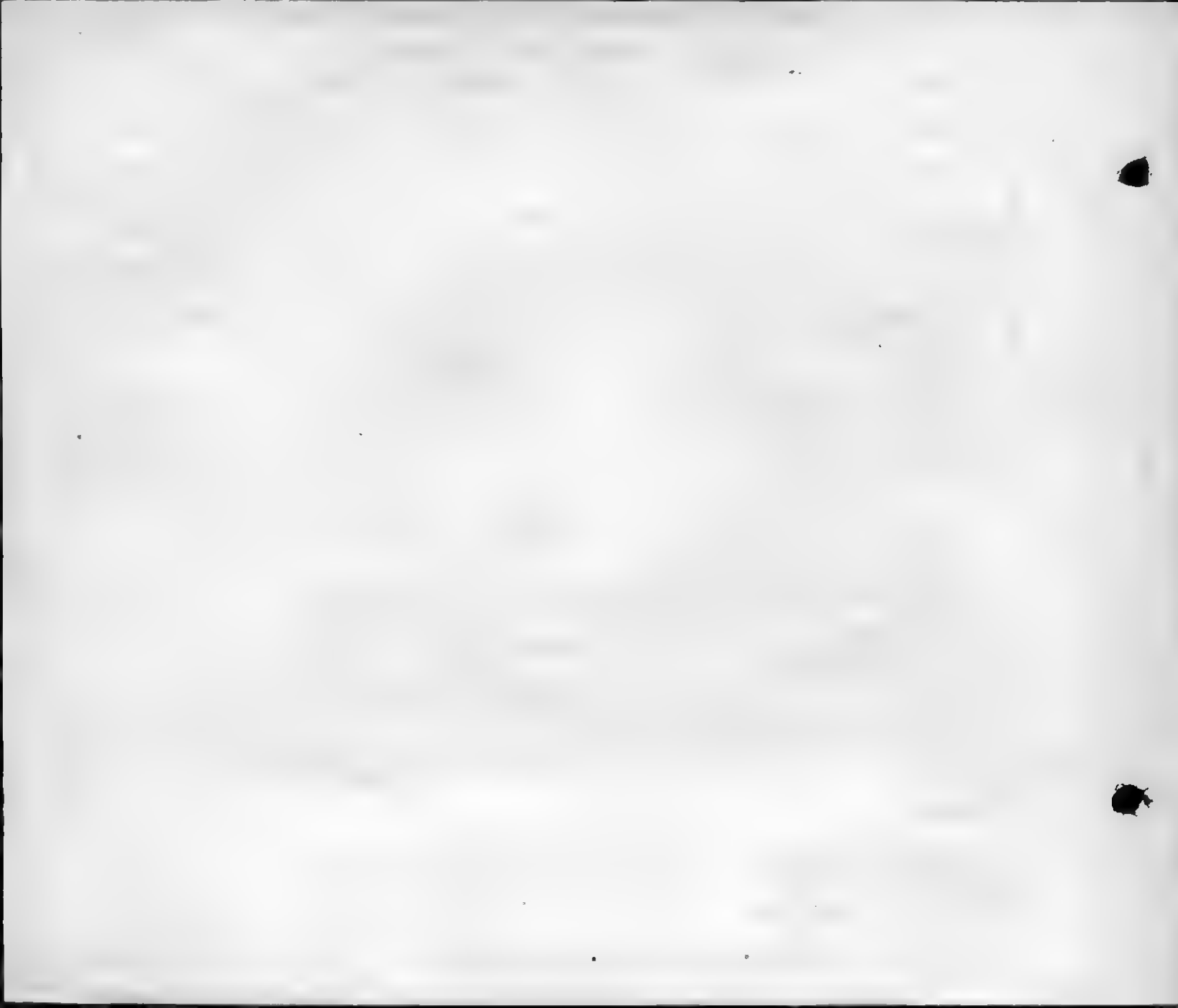
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rodgers Forge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 44 Dunkirk Road		d. STREET ADDRESS 44 Dunkirk Road	
3. NAME OF DECEASED (Type or print) First RICHARD Middle ARTHUR Last MOORE		4. DATE OF DEATH Nov. 19, 1959 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1905
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martz Arnold Moore		14. MOTHER'S MAIDEN NAME Fannie Carlton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Vera G. Moore-44 Dunkirk Rd-Balto.12	
17. INFORMANT Vera G. Moore-44 Dunkirk Rd-Balto.12		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Brain 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Lung metastasizing DUE TO (c) Lung		INTERVAL BETWEEN ONSET AND DEATH 1400 30da	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1959 to Nov 14, 1959 that I last saw the deceased alive on Nov 19, 1959 , and that death occurred at 1:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wm Cook-Towson, Inc. Towson, Md. Nov 23 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1959	
22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. Towson, Md.		24. REC'D BY REGISTRAR DATE NOV 23 59	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12315

Item 1 Film 652 11-16-59 e

CERTIFICATE OF DEATH

Reg. Dist. No.

12294

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb <u>2 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3002 Churchland Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Victoria</u> Middle <u>—</u> Last <u>None</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 6, 1900</u>	
9. AGE (In years last birthday) <u>58 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>303-12-9499</u>				17. INFORMANT <u>George Foster</u> Address <u>2097 E. Edmond St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>433.1</u> DUE TO <u>Cerebral embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>chronic hypocalcemia</u> DUE TO (c) <u>cardiac fibrillation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>one year</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Oct 30</u> , 19 <u>59</u> , to <u>Nov 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D. ADDRESS (Street, city or town, state) <u>1725 Reisterstown Rd.</u>				DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>PALMER F. WILLIAMS</u>				Pikesville 8. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Helmore</u> ADDRESS <u>519 Mosher St</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. W. S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12316

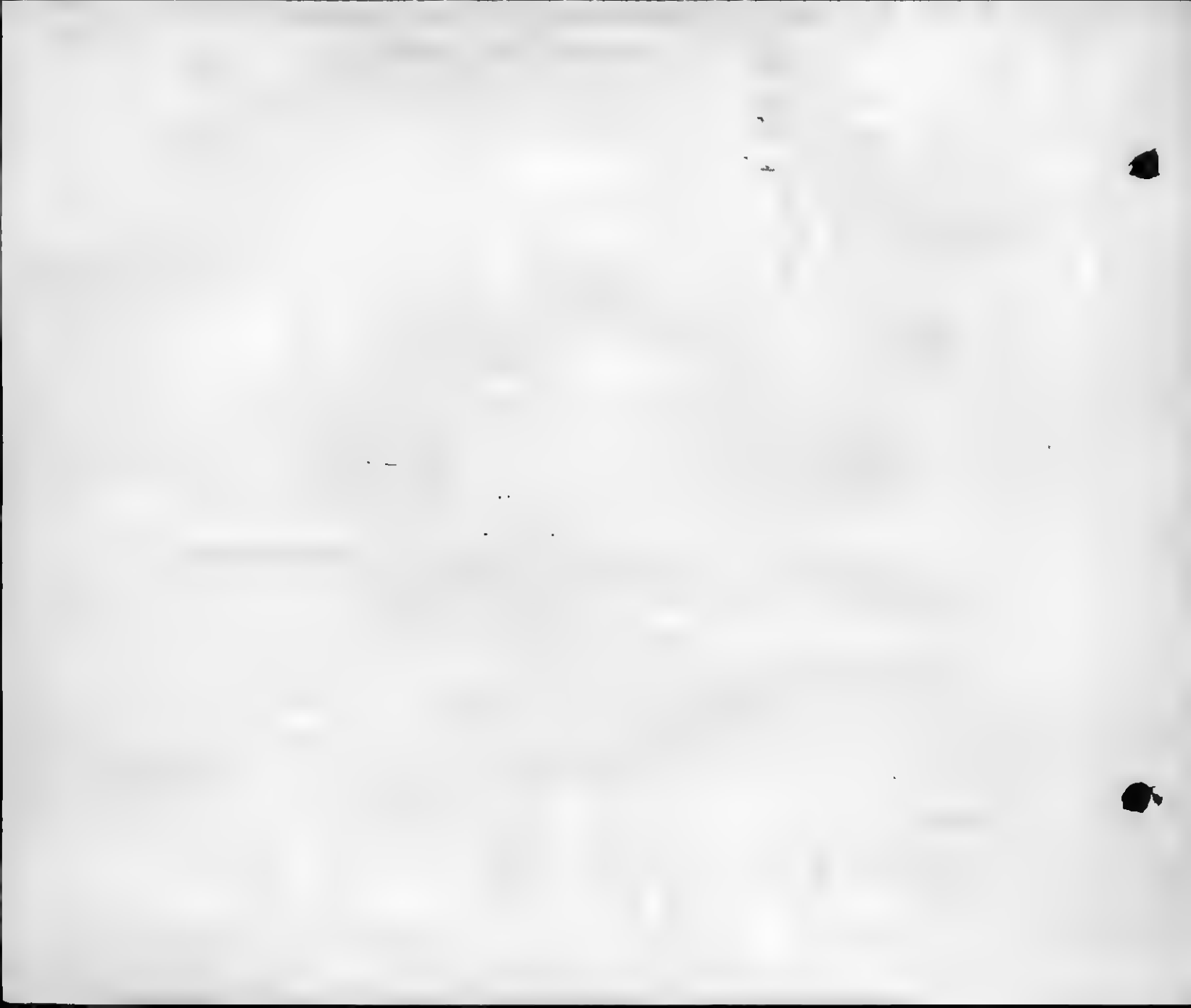
CERTIFICATE OF DEATH

12295

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1025 SYMINGTON AVE</u>				d. STREET ADDRESS <u>1102 S. SYMINGTON AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>J.</u> Last <u>MORRISER</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 13, 1899</u>	
9. AGE (In years last birthday) <u>60 yrs</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAFTSMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R.R</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>John Morriser</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fitzpatrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.I</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Harold Morriser - 107 Symington Ave</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hysterical intestinal hemorrhage</u> <u>197X</u> DUE TO <u>Carcinoma of pancreas with liver metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 m</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 26, 1959</u> to <u>Nov. 29, 1959</u> , that I last saw the deceased alive on <u>Nov. 29, 1959</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Snyder</u> M.D.				ADDRESS (Street, city or town, state) <u>6348 FREDERICK RD</u> DATE SIGNED <u>12/1/59</u>			
PHYSICIAN'S NAME (Type) <u>JOHN W. SNYDER, M.D.</u>				BALTIMORE 28, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bald. National Cem.</u>		22d. LOCATION (City, town or county) (State) <u>Balto.</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fairfax Funeral Home - Catonsville, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



X 1 X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

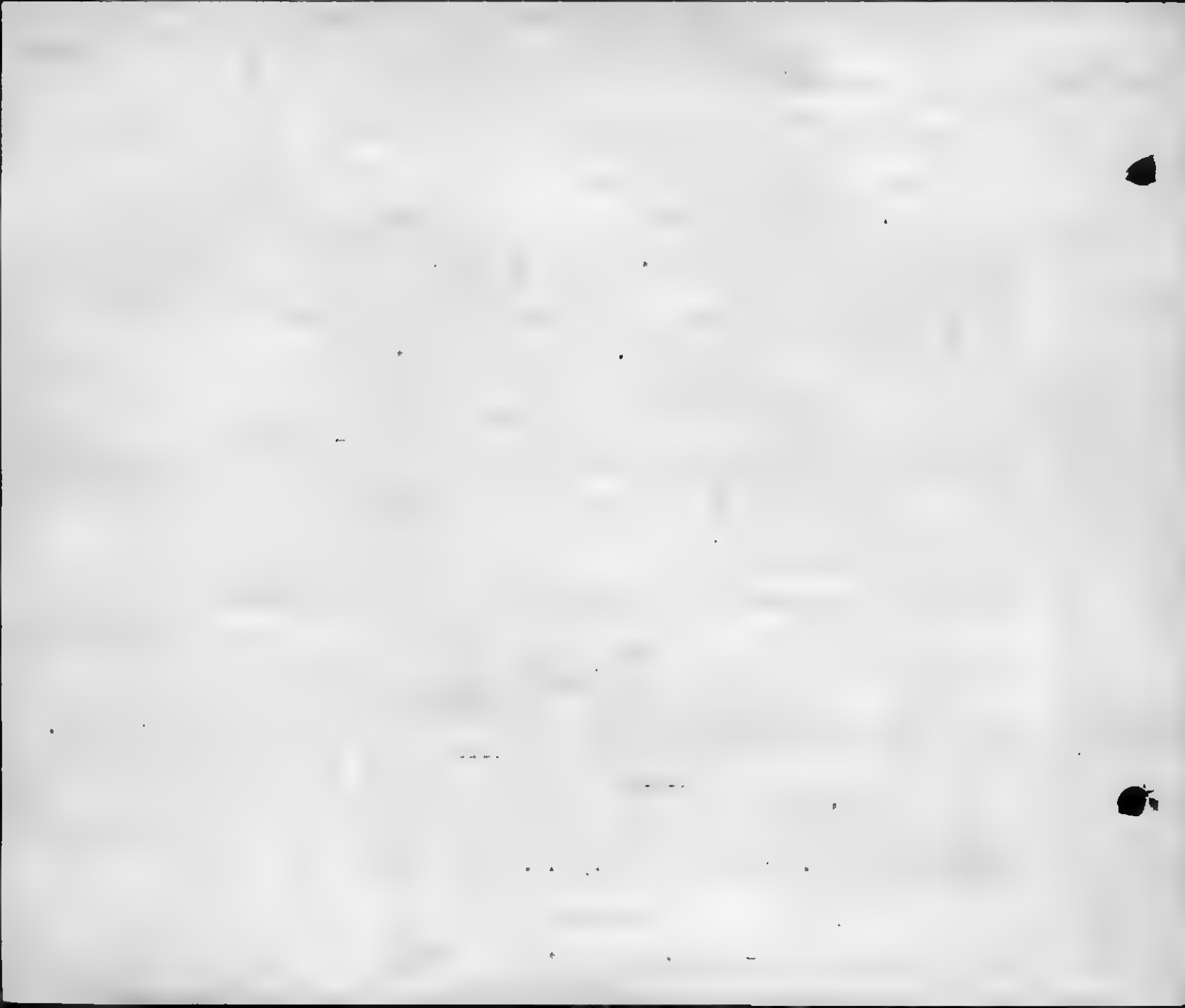
VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12296

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
RAYMOND F. MROZINSKI		November 15 19 59	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. AGE (In years last birthday)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/10/37
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Food Mach. Corp	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT		Address	
Family - Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication and smoke inhalation 020X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Conflagration DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
Auto wreck with resulting conflagration			
21a. TIME OF INJURY Month, Day, Year 5 Hour xx a.m. 11/15 19 59	21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	21d. (City or town) (County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		DATE SIGNED 11/15/59	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
W. Bradley King, Jr., M.D.		Baltimore	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
B	11/19/59	Parlwood	Baltimore
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
McCully Funeral Homes - 130 E. Fort Ave.		NOV 17 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
		C. J. King	



CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

Katherine M. Mullin

2. DATE OF DEATH 11/13/59

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Armcast Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3700 Greenmount Avenue

190

c Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1876

9. AGE (In years last birthday)

83

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Baltimore Co.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Patrick Flanagan

14. MOTHER'S MAIDEN NAME

Margaret Sharkey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS
Mrs. Paul J. Flynn-3700 Greenmount

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO Arteriosclerotic Cardiovascular Disease with Hypertension

4 weeks
5 years

422.1 ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Diabetes Mellitus
DUE TO

2 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

22. I certify that (I) (this hospital) attended the deceased from July 15, 1958 to 1959, that (I) (we) last saw the deceased alive on 1959, and that death occurred at 5 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Philip D. Flynn

23B. ADDRESS

11 E. Chase St

23C. DATE SIGNED

11/16/59

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

11/17/59

Cathedral Cem

City

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

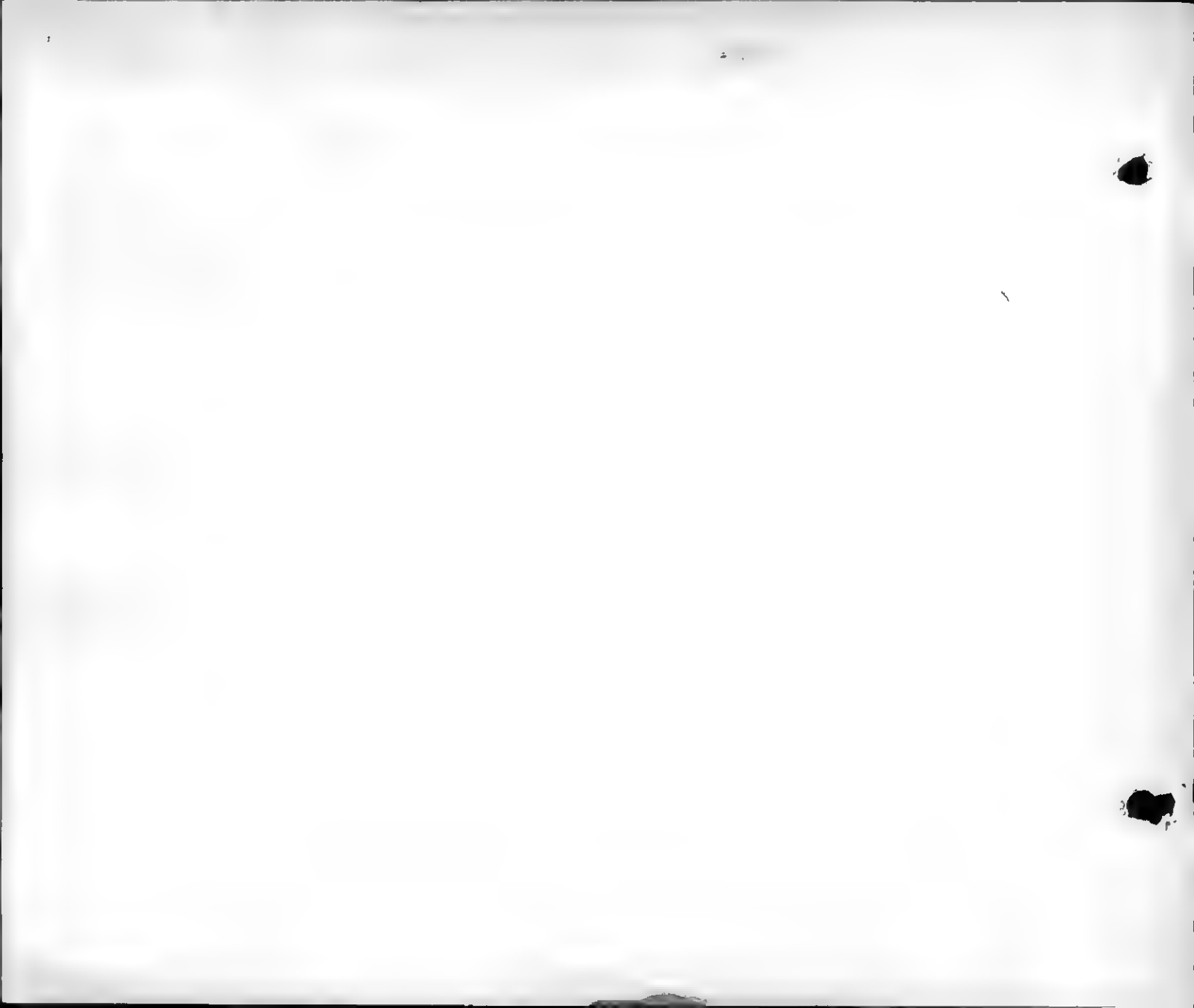
NOV 16 1959

(Signature)

(Signature)

(Signature)

THIS IS A PERMANENT RECORD. PLEASE TYPE, OTH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information carefully supplied. Physicians: please write the causes of death clearly and leg HIS CERTIFICATE MUST WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12319

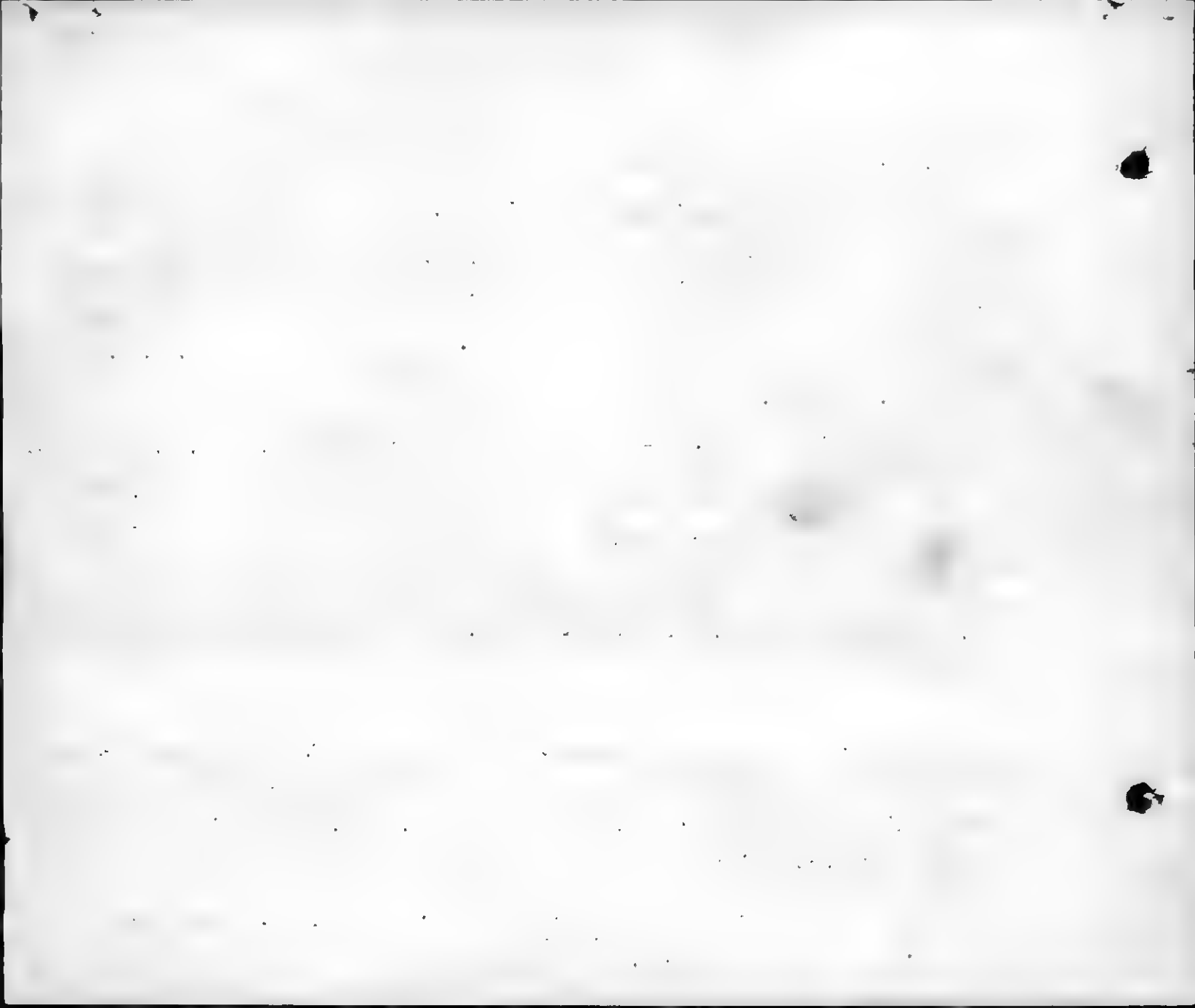
CERTIFICATE OF DEATH

12298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY (13) 3VJ1-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1508 N. Rutland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES ADAM MUTH, JR.			4. DATE OF DEATH Month Day Year November 4 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1911	9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Charles A. Muth, Sr.				
14. MOTHER'S MAIDEN NAME Mary Burnham			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				
16. SOCIAL SECURITY NO. 212-10-6423		INFORMANT Address Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE BLEEDING GASTRIC ULCER 540.0 XEROX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE ANEMIA XEROX (c) CIRRHOSIS OF LIVER INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN 9 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Esophageal Varices. 2. Edema of lungs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.		
21. I certify that I attended the deceased from October 29, 1959 , to November 4, 1959 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. VAH, BALTO. 18, MD. FORT HOWARD DIVISION DATE SIGNED 11/5/59 ACTUAL SIGNATURE John W. Crawford PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. 11/5/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-9-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard Huck		24a. REC'D BY REGISTRAR NOV 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Evans				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



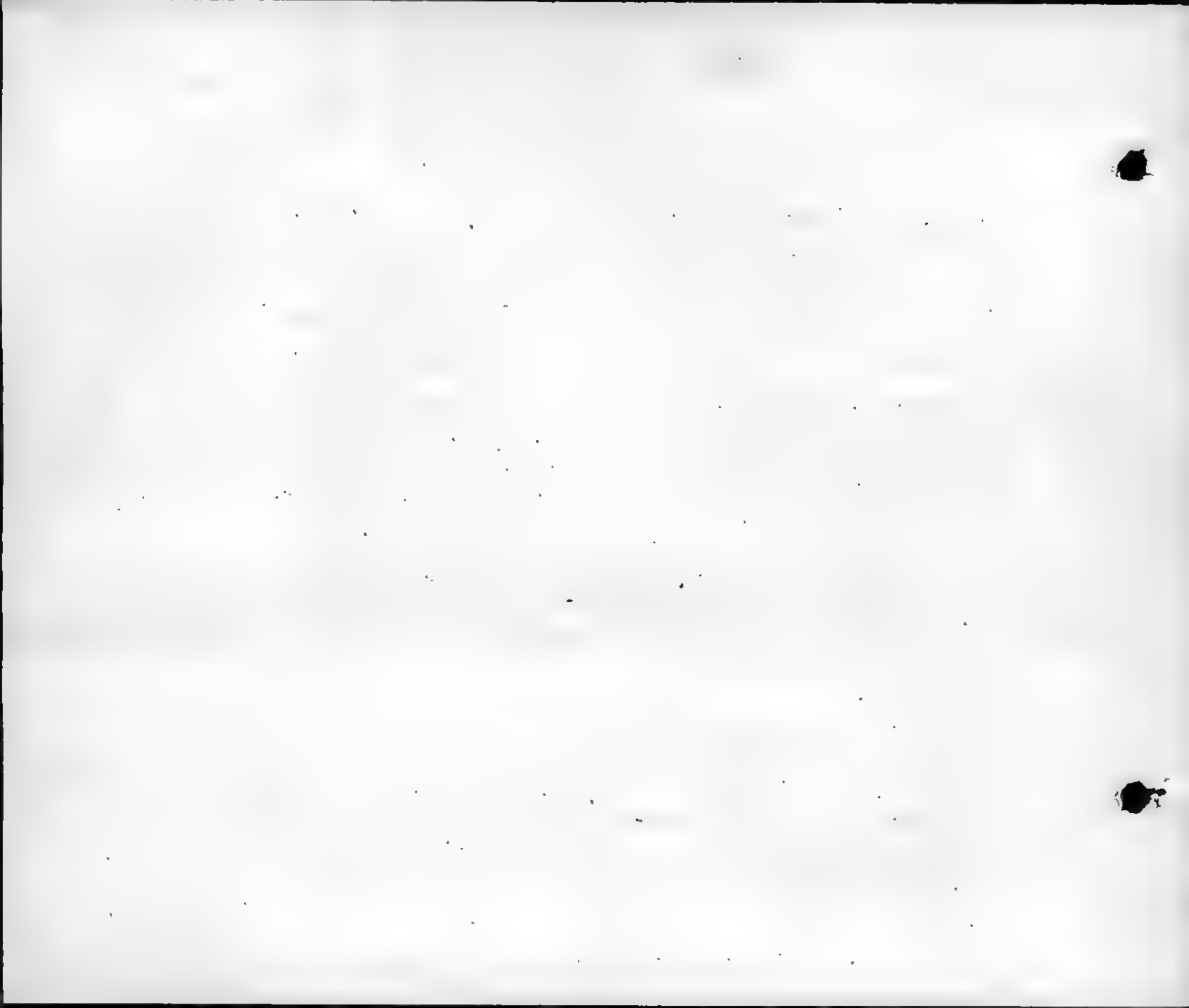
12320

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springtown Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks d. STREET ADDRESS Springtown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edwin Middle H. Nicholson Last Nicholson		4. DATE OF DEATH Month Nov. Day 18 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1886
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) real estate	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob K. Nicholson		14. MOTHER'S MAIDEN NAME Fannie Ogher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Informant Olive Nicholson Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypercalcemia DUE TO (c) coronary insufficiency			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 yr. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-59 to 11-18-59 that I last saw the deceased alive on 11-17-59 and that death occurred at 1:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Peisterstown, Md DATE SIGNED 11-19-59			
ACTUAL SIGNATURE James G. Saffell		PHYSICIAN'S NAME (Type) James G. Saffell	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11-21-59	22c. NAME OF CEMETERY OR CREMATORY Parkwood cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Rd		24. REC'D BY REGISTRAR NOV 23 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director, or the registrar, if the death occurs in a hospital or attending physician. Pages 3 and 4 should be filled with the information required by the registrar. Pages 1 and 2 should be filled with the information required by the registrar. Pages 3 and 4 should be filled with the information required by the registrar.



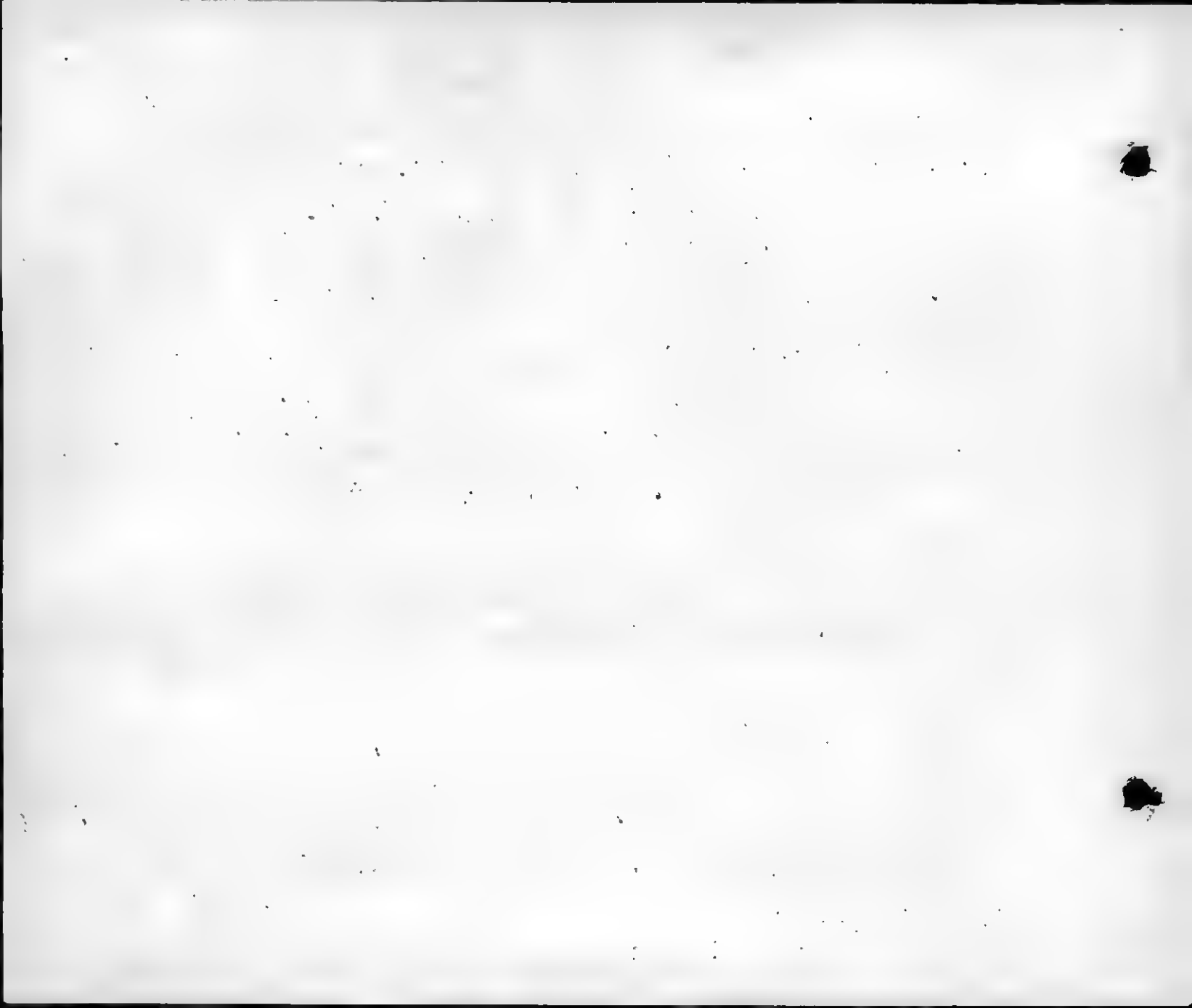
TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12321
CERTIFICATE OF DEATH

12300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balta</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>25yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Rayville Rd.</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert P. Noel</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 9, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pvt. Dept. Laborer Service Station</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Noel</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>512-033987</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition, Autamiasis</u> DUE TO (c) <u>Malnutrition, Autamiasis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition, Autamiasis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> p. m. <u>11, 30</u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/29</u> , 19 <u>59</u> , to <u>11-30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Herbert Mueller</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton P.O. Md</u> DATE SIGNED <u>12/1/59</u>	
PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER</u>		<u>PARKTON P.O. MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>DEC 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



12322

CERTIFICATE OF DEATH

Reg. Dist. No.

12301

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE MARYLAND b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ADDIE Middle NORRIS Last NORRIS		4. DATE OF DEATH Month NOV Day 5 Year 1959	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-31-1870
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ELLICOTT CITY-MD		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME EDWARD E. NORRIS		14. MOTHER'S MAIDEN NAME EMILINE APPLEBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank R. Smith Jr. Cockeysville, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from 9-29 , 19 47 , to 11-5 , 19 59 , that I last saw the deceased alive on 11-4 , 19 59 , and that death occurred at 6:40 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Walter T. Hines		ADDRESS (Street, city or town, state) Cockeysville, Md	
DATE SIGNED 11/5/59		M.D. Cockeysville, Md	
PHYSICIAN'S NAME (Type) William Cook, Inc., 1217 St. Paul Street		22a. REC'D BY REGISTRAR DATE NOV 6 '59	
22b. REGISTRATION BURIAL		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	
22d. LOCATION (City, town, or county) (State) Ellicott City, Md		22e. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12323

CERTIFICATE OF DEATH

12302

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 8mth13dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 834 Brooks Lane				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Harry Last Palmer				4. DATE OF DEATH Month November Day 3 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1892	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Salesman				10b. KIND OF BUSINESS OR INDUSTRY Mutual of Omaha		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME (Unknown) Palmer				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 215-22-3567			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infarctive myocardial fibrosis DUE TO (c) Hypertensive and arteriosclerotic cardiovascular disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 27, 19 59 , to Nov. 3, 19 59 , that I last saw the deceased alive on Nov. 3, 19 59 , and that death occurred at 7:15a M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachler				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 11-3-59			
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-6-59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR NOV 4 '59		24b. REGISTRAR'S SIGNATURE William S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12324

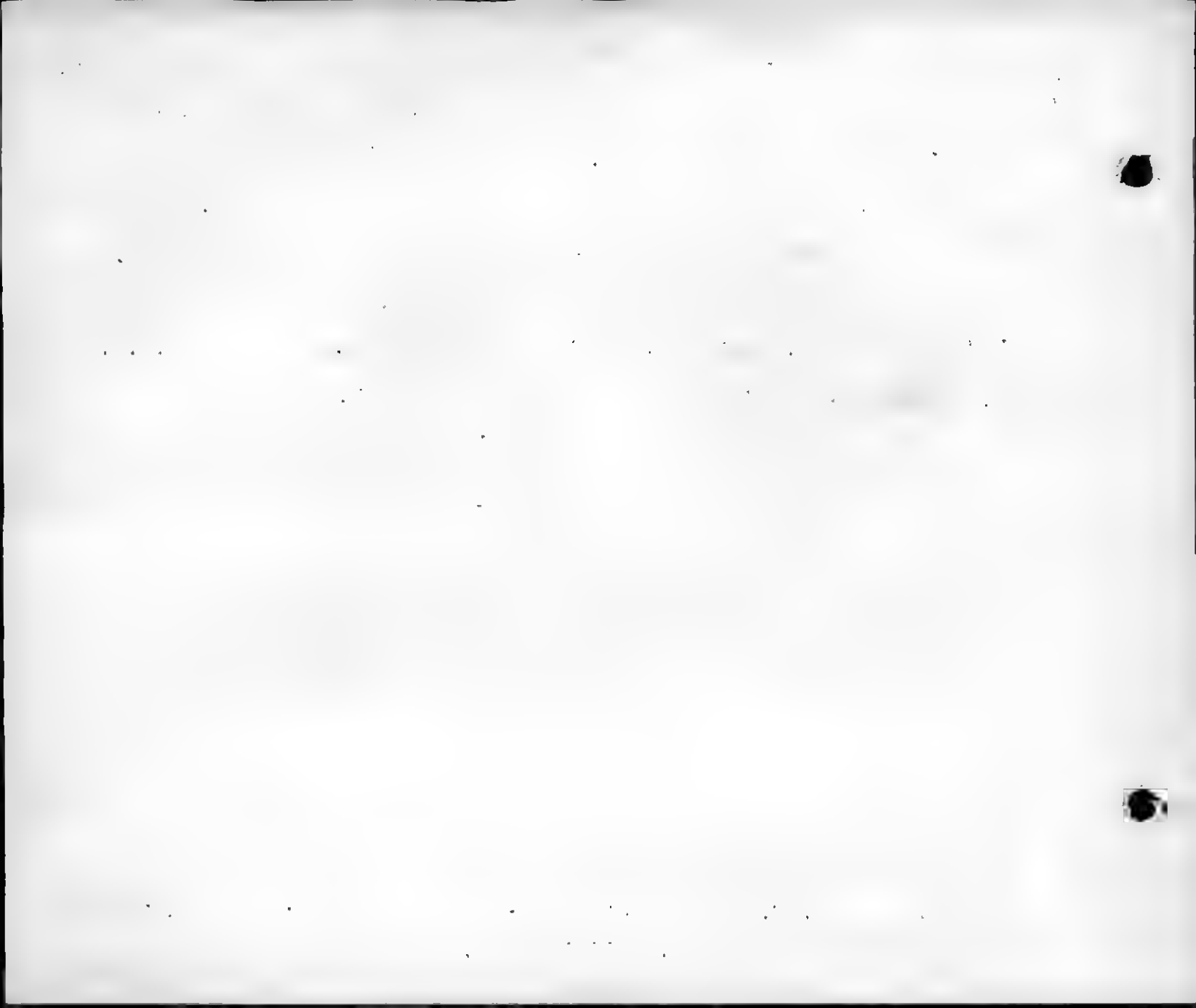
CERTIFICATE OF DEATH

Reg. Dist. No. 12303

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 9 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 646 CHARLES STREET AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLIFTON TODD PERKINS		4. DATE OF DEATH NOVEMBER 10, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 20, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN - COMM. MENTAL HYGIENE		10b. KIND OF BUSINESS OR INDUSTRY AUBURN MAINE	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. EVERETT C. PERKINS		14. MOTHER'S MAIDEN NAME LOUISE M. TODD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address MRS ANNIE MARGARET PERKINS	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix 1530 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-9 , 19 59 , to 11-10 , 19 59 , that I last saw the deceased alive on 11-9 , 19 59 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert E. Ensor M.D.		DATE SIGNED 29 Alleghany Ave, Towson 11-11-59	
PHYSICIAN'S NAME (Type) ROBERT E. ENSOR, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/12/ 59	22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY	22d. LOCATION (City, town, or county) (State) AMESBURY MASSACHUSETTS
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HENRY SANDER & SONS INC. BALTIMORE MD.		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

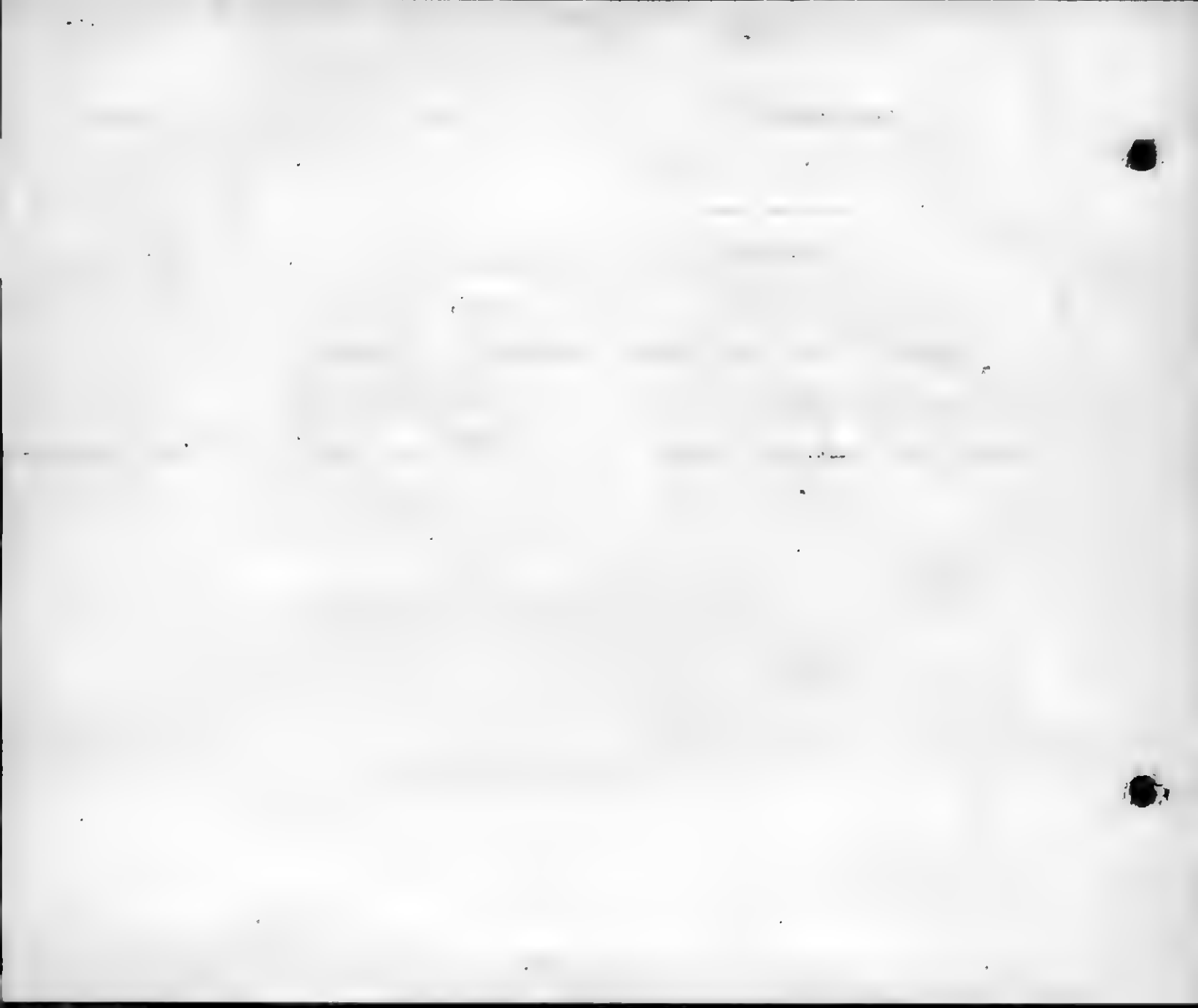
12325
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No.

12304

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Pr Georges ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md. 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Lutheran Home		d. STREET ADDRESS Kennedy St	
3. NAME OF DECEASED (Type or print) Katherine		4. DATE OF DEATH PETERS NOV 18, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 1 Hours 1 Min 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk Post Office Department		10b. KIND OF BUSINESS OR INDUSTRY France	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Peters		14. MOTHER'S MAIDEN NAME Barbara Schini	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Anna Kramer		Address Glen ndale Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X (1) - Cerebral Hemorrhage (Rt. side) 7 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (2) Hypertensive Heart Disease 5 yrs. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1959 to Nov. 18, 1959 , that I last saw the deceased alive on Nov 18-59 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts Baltimore Md. 11-18-59	
PHYSICIAN'S NAME (Type) Earl L. Chambers		DATE SIGNED 4108 Liberty Hts Baltimore Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 21, 1959	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Bowie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

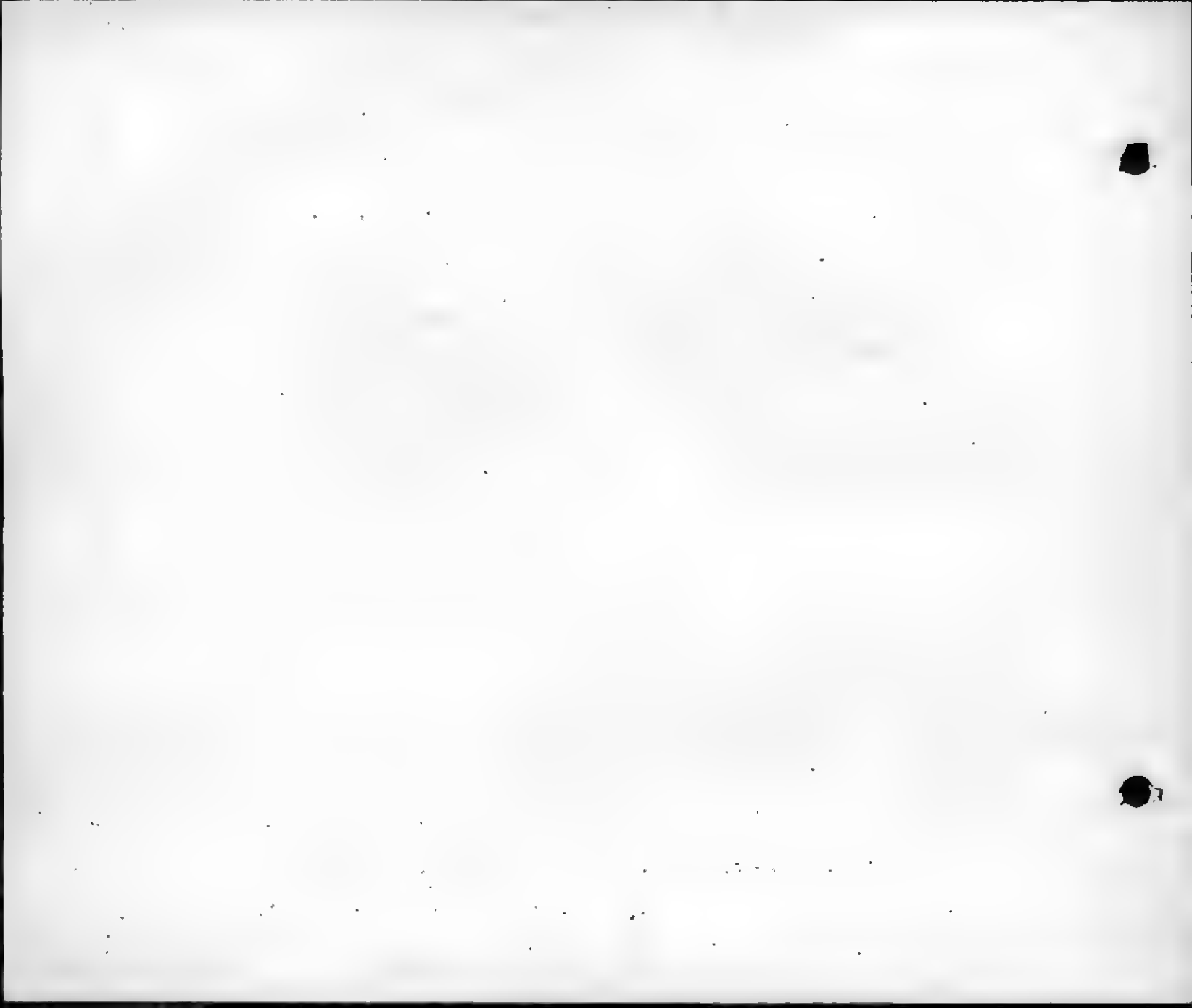
12326

CERTIFICATE OF DEATH

Reg. Dist. No.

12305

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>2</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>4</u> yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6635 Ritchie Highway</u> <u>0230</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>Brooklyn, Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Eleanor</u> Last <u>Phelps</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Franklin Manshau</u>				14. MOTHER'S MAIDEN NAME <u>Annie Elizabeth Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		INFORMANT <u>Dr. J. B. H. H. College Manor</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331x</u> DUE TO <u>Cerebral arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>present</u> , 19 <u></u> , that I last saw the deceased alive on <u>10/30/59</u> , 19 <u>59</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest C. Brown Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>11/2/59</u>			
PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr.</u>				<u>1101 N. Calvert St.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc. 1900 Eutaw Place</u>				24a. REC'D BY REGISTRAR <u>NOV 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

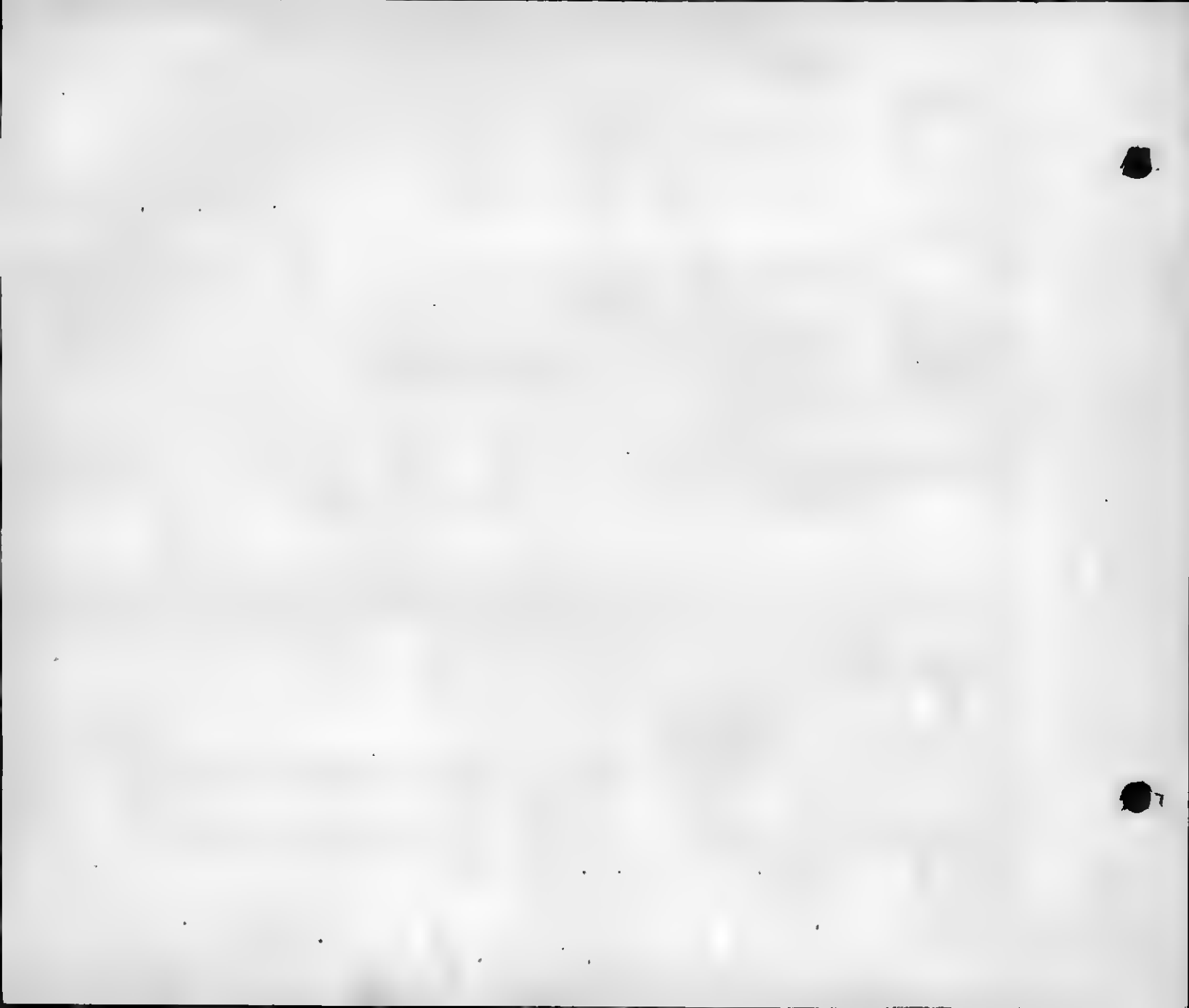
12306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3yrlmth7dys			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS Route #10 - Box 37 - Hillers, Is.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Josephine Middle Pitelli Last Pitelli				4. DATE OF DEATH Month November Day 9 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 19, 1909	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS				10b. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Vincent Pitelli				14. MOTHER'S MAIDEN NAME Catherine AKERZA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 923.7 DUE TO Foreign material in trachea and bronchus (aspirated food) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) accident DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Foreign material in trachea and bronchus							
20c. TIME OF INJURY Month, Day, Year 9-35-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville Baltimore Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE George M. Kieffer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 12/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
				22d. LOCATION (City, town, or county) (State) 4430 Belair Rd.			
23. FUNERAL DIRECTOR'S SIGNATURE Frank Weller Noe				ADDRESS 322 S. High St.		24a. REC'D BY REGISTRAR DATE NOV 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. King			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

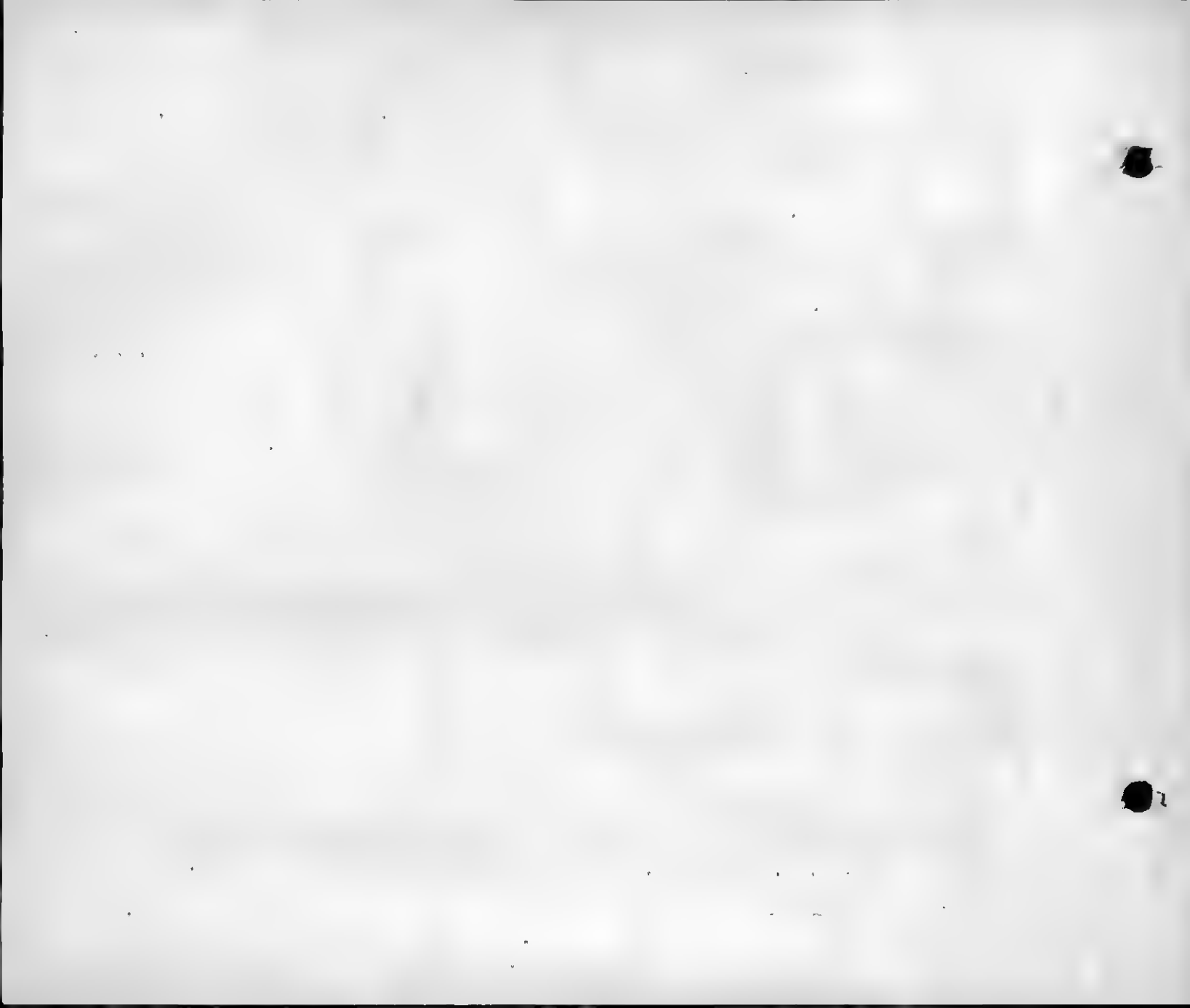
Reg. Dist. No. **12307**

12328

1. PLACE OF DEATH a. COUNTY <u>Balti ore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>21 Melrose Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>21 Melrose Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gabriel</u> Middle <u>Pollock</u> Last 4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1959</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 1 1906</u> 9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Ind. Caroline</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Pollock</u> 14. MOTHER'S MAIDEN NAME <u>Annie Louise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>2-7-610734</u> 17. INFORMANT <u>John W. Pollock</u> Address <u>1032 N. Gilmer ST.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Nov. 14, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Star Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville, Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William T. Harnsey</u> ADDRESS <u>578 W. Biddle St.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12308

Reg. Dist. No.

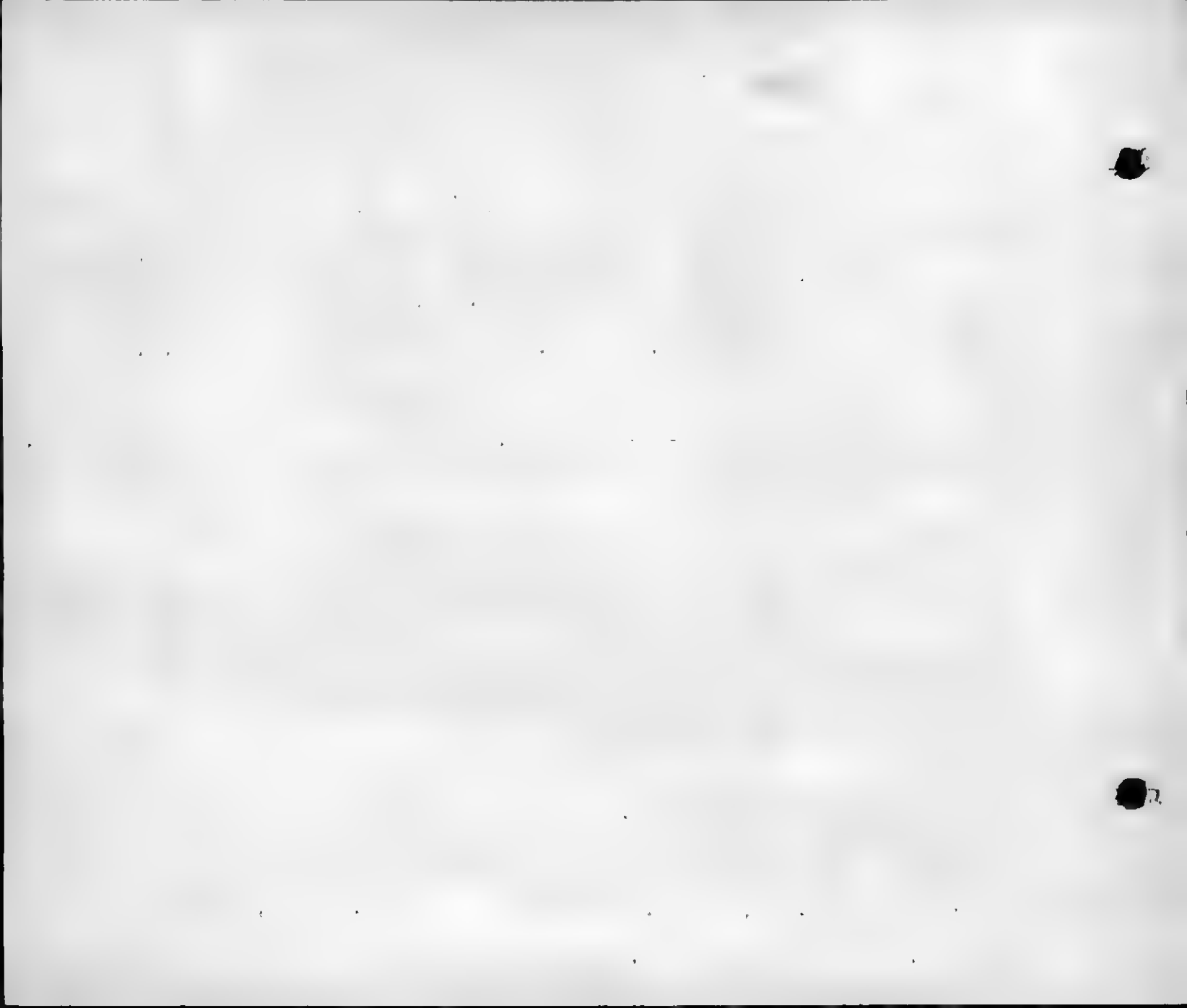
FOR STATE
HEALTH DEPT.

12201

Items 8 & 9, Film G-52 11/24/59.cac.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b ?		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2727 Old North Point Road						e. STREET ADDRESS 106 German Hill Road			
3. NAME OF DECEASED (Type or print) Thomas		First Patrick		Middle Porter		Last		4. DATE OF DEATH Month November Day 6 Year 19 59	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1896 Sept. 28, 1891		9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer on		10b. KIND OF BUSINESS OR INDUSTRY Penna. R R Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 205-05-2431		17. INFORMANT Address Mrs. Esther Tabaka 106 German Hill Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4 DUE TO ASCVD Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE M. B. Davis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) M. B. DAVIS M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Nov. 10, 59 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery 22d. LOCATION (City, town, or county) (State) St. Clair, Pennsylvania									
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda				ADDRESS 7922 Wise Ave. 22, Maryland		24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

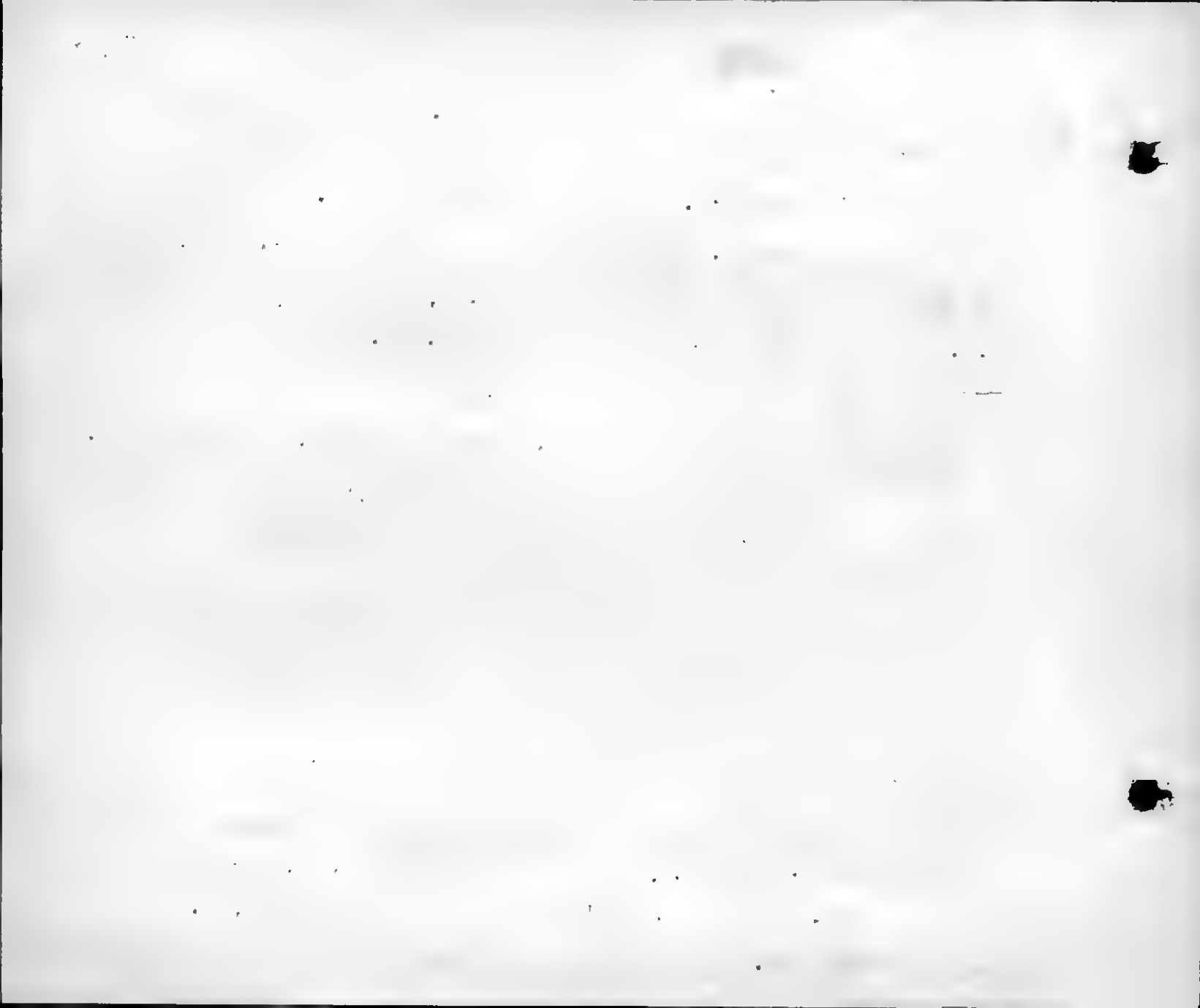
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12209

CERTIFICATE OF DEATH

Reg. Dist. No. 12309

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1711 Selma Ave.		e. STREET ADDRESS 1711 Selma Ave.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma J. Middle Pullen Last		4. DATE OF DEATH Month Nov. Day 18 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1870	9. AGE (In years lost birthday) 89 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hickmann		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Mrs. Mildred Parsons, 1711 Selma Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerotic cardiovascular disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1957 to Nov 18, 1959 that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED					
ACTUAL SIGNATURE George A. Knipp		M.D. Baltimore, 29, Maryland			
PHYSICIAN'S NAME (Type) George A. Knipp, M.D.					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21/59		22c. NAME OF CEMETERY OR CREMATORY St. Paul's	
22d. LOCATION (City, town, or county) (State) Violetville, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Witzke Funeral Directors 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12329

CERTIFICATE OF DEATH

Reg. Dist. No.

12310

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARBOR VIEW		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARBOR VIEW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 630 S. 47TH ST. #24		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY		4. DATE OF DEATH Month NOV. Day 10 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 4, 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10	11. IF UNDER 24 HRS Hours 10 Min 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOSEPH RASSELE		14. MOTHER'S MAIDEN NAME MOSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-18-0629	
17. INFORMANT LENA RASSELE		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 13 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 21, 1958 to Nov 11, 1959 , that I last saw the deceased alive on Nov 11, 1959 , and that death occurred on Nov 11, 1959 at 6:42 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene F. Nevy		DATE SIGNED 11-12-59	
PHYSICIAN'S NAME (Type) Eugene F Nevy M.D.		M.D. 7001 Morningside Ave. Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-13-59	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler		ADDRESS 901 S. CONKLING ST BALTO., MD.	
24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE C. H. & K. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12330

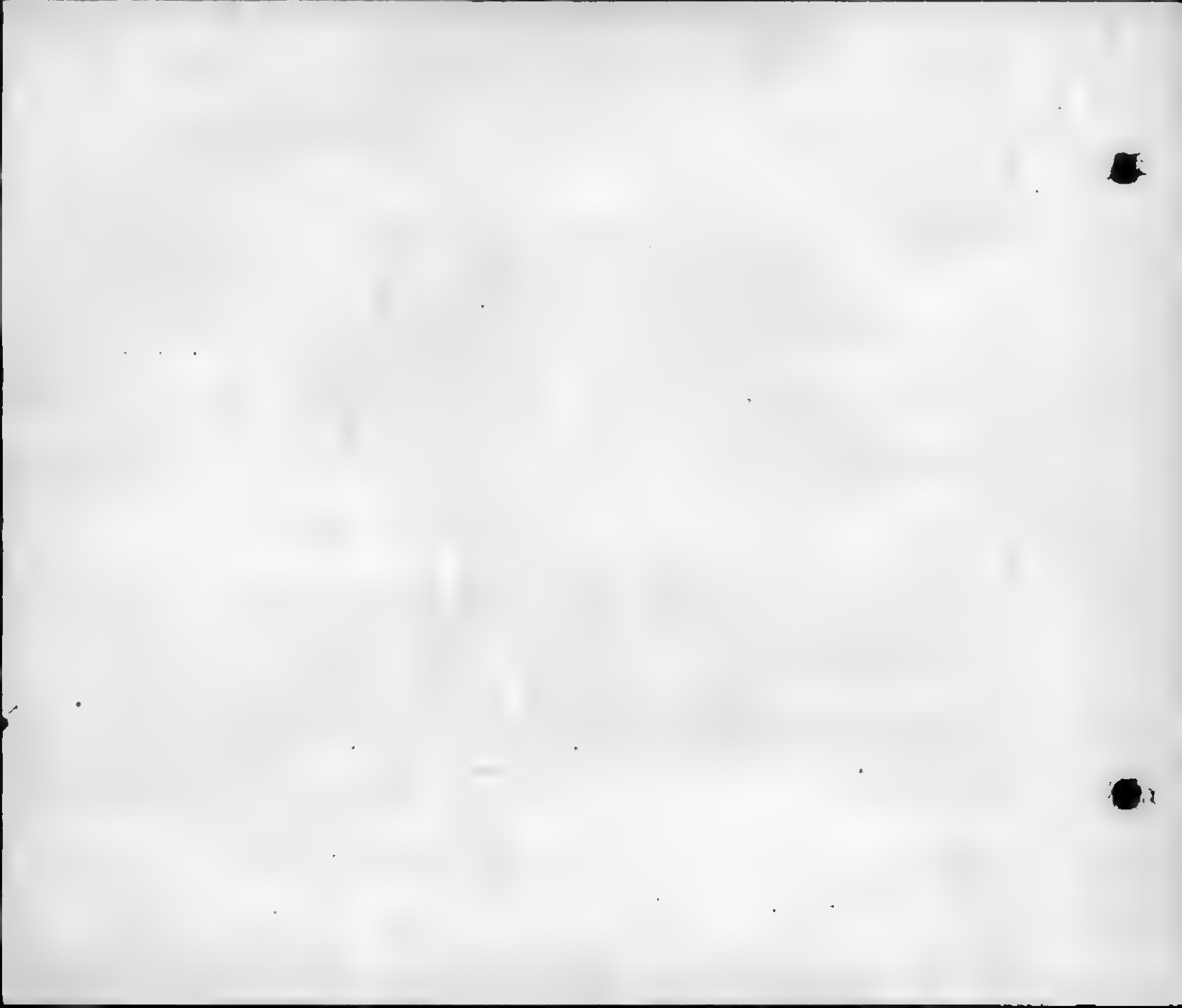
CERTIFICATE OF DEATH

12311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>8yr10mth16dys</u>				d. STREET ADDRESS <u>1808 St. Paul Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>William</u> Last <u>Redford</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1912</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Unknown)</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Raymond Redford, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Catherine Chapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>220-14-4093</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic coronary thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 months</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Sept. 11, 1959</u> , to <u>Nov. 27, 1959</u> , that I last saw the deceased alive on <u>Nov. 27, 1959</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>11/27/59</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal, Burial- Nov. 30, 1959</u>	22b. DATE THEREOF <u>Nov. 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Birchview</u>		22d. LOCATION (City, town, or county) <u>Richmond, Virginia</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Bliley</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

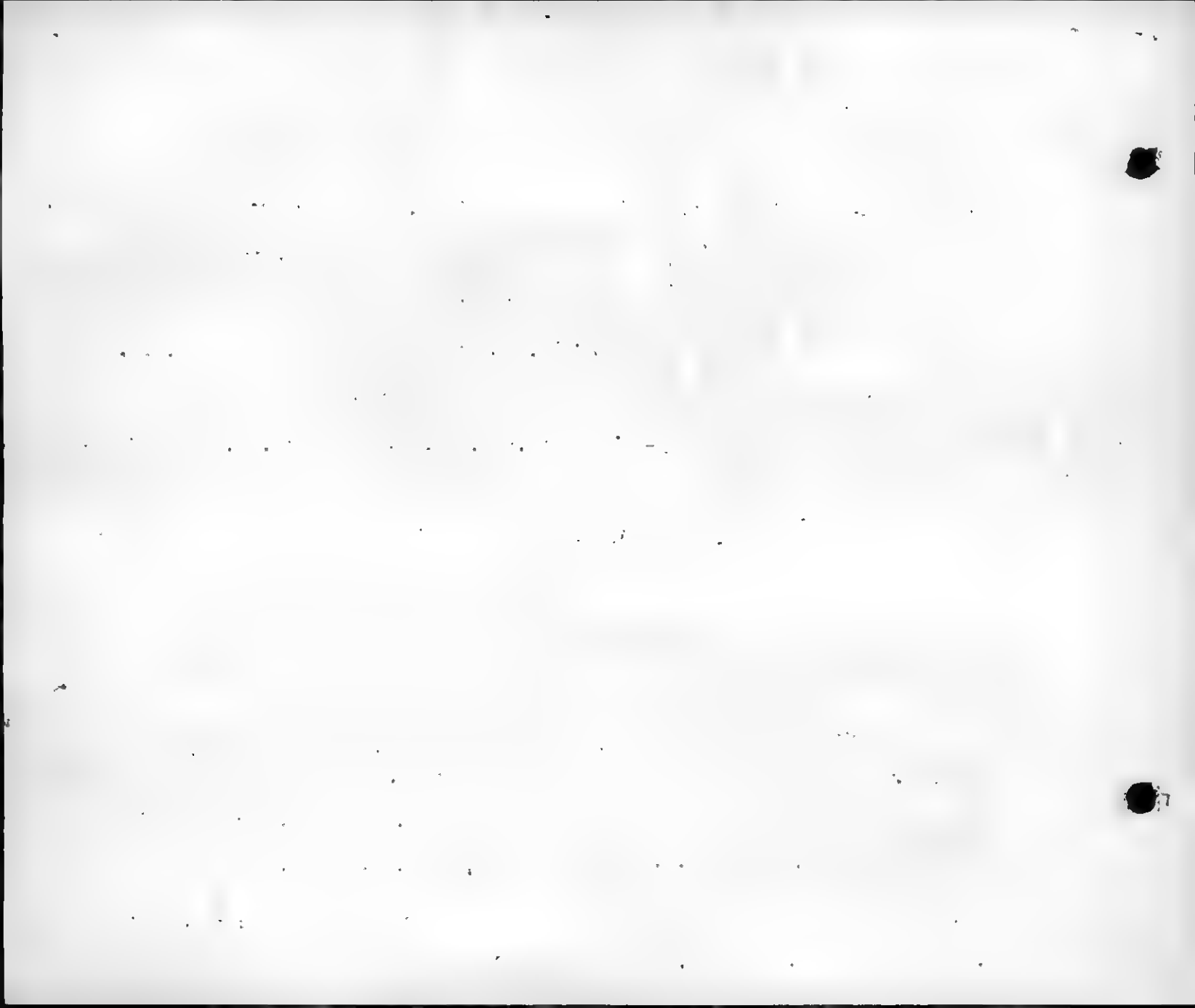
12331

CERTIFICATE OF DEATH

Reg. Dist. No.

12312

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 25 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN W. REIMER Served As: JOHN W. REIMERS		4. DATE OF DEATH Month November Day 25 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/97
9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Venetian Blind Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Reimer		14. MOTHER'S MAIDEN NAME Anna Lohn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO 216-03-7077	
17. INFORMANT Clin. Rec. VAH, Balto 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) DIABETES MELLITUS XXXX (b) MARKED GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 24, 1959 to November 25, 1959 and that death occurred at 1:10 P.M. from the causes and on the date stated above. Arthur T. Faulk, M.D. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIVISION DATE SIGNED 11/26/59			
ACTUAL SIGNATURE		M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION	
PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.		VAH, BALTO. 18, MD. FT. HOWARD DIVISION	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
ADDRESS 6009 Harford Road Baltimore 14, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

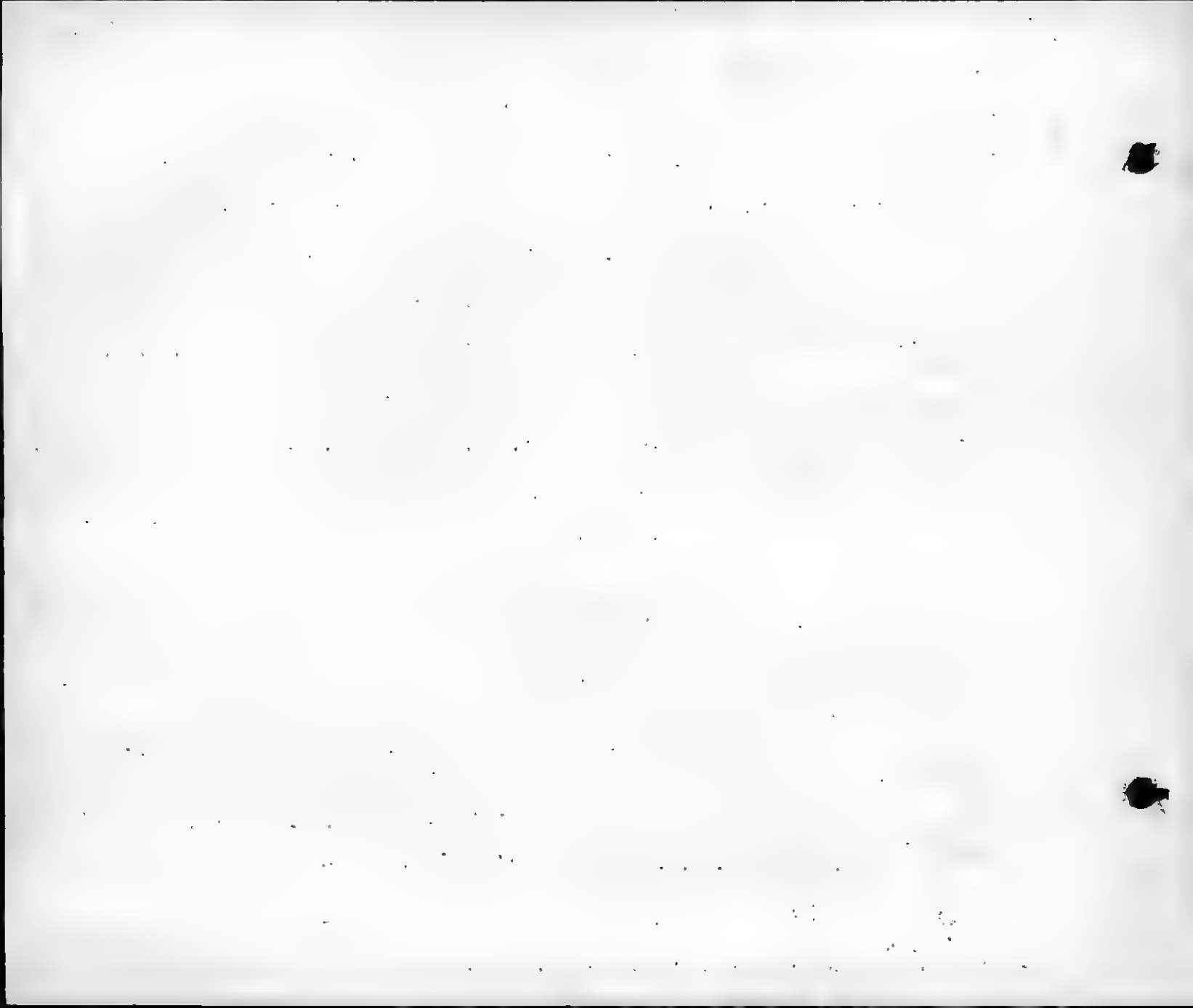
12313

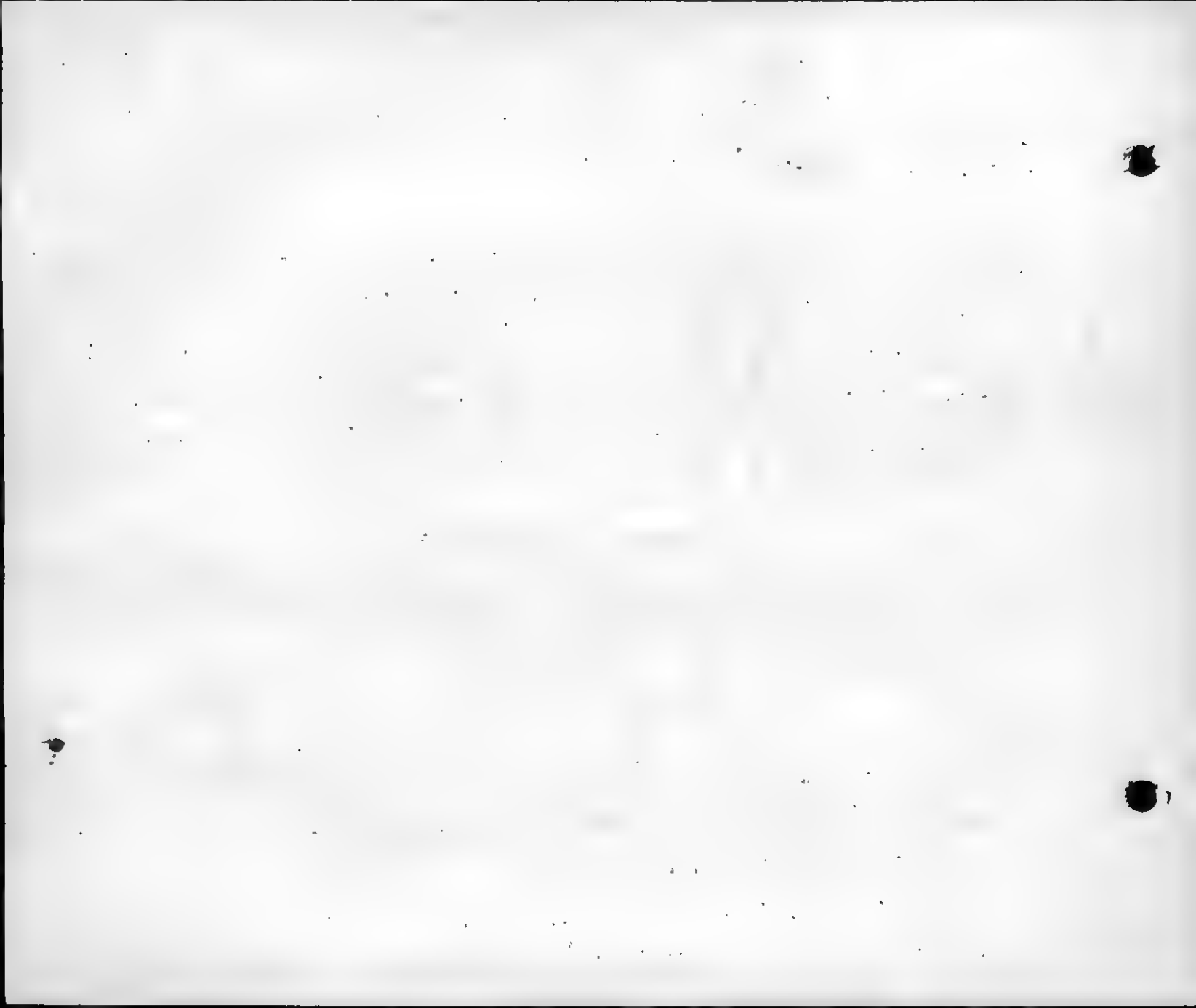
12332

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 616 South 48th Street, Baltimore d. STREET ADDRESS 616 South Forty-eighth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last REITZ		4. DATE OF DEATH Month November Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 7, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 24 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector (Car)		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Reitz		14. MOTHER'S MAIDEN NAME Carrie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 717-07-7313	
17. INFORMANT Clin. Rec., VAH, Balto. 18, Md., Fort Howard Div.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 422.1 DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6. CARCINOMATOSIS, GENERALIZED INTERVAL BETWEEN ONSET AND DEATH 1 DAY 10 DAYS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 14 1959 to November 24 1959 , and that death occurred at 8:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIV. DATE SIGNED 11/24/59 ACTUAL SIGNATURE John W. Crawford M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV. PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/59	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber ADDRESS George A. Weber Funeral Home, 705 S. Ann St. Balto. Md.		24a. REC'D BY REGISTRAR NOV 25 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

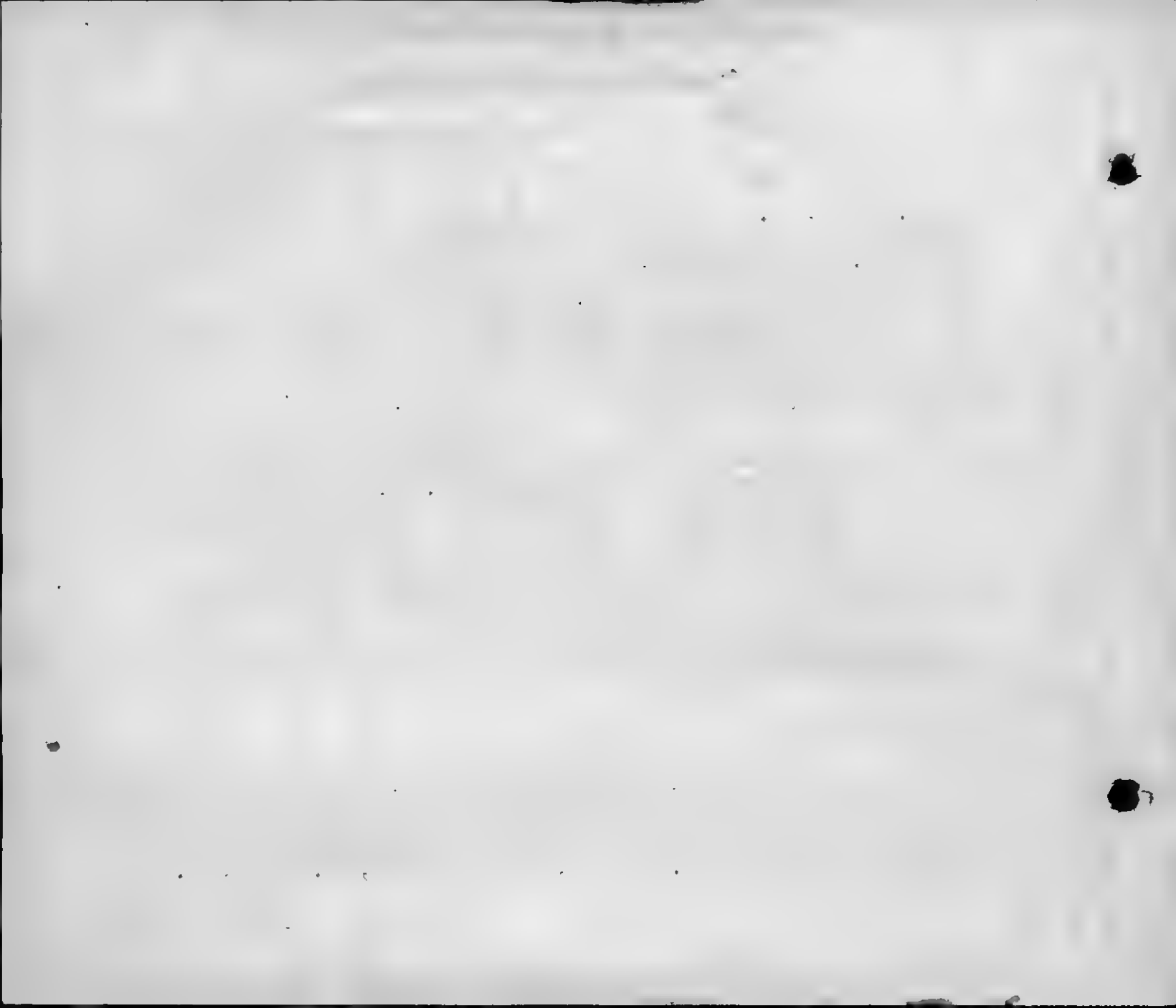
12315

CERTIFICATE OF DEATH

12334

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		STATE <u>Md.</u> COUNTY <u>Pr. George</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Mt. Wilson, Md.</u>		LENGTH OF STAY (In this place)		TOWN <u>Suitland 1-X-</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>2315 Wingate Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Lucille Carrola Robinson</u>				<u>11 10 19 59</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>F</u>		<u>C</u>		<u>S</u>		<u>10-23-1922</u>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>37</u> yrs.		<u>Housework</u>		<u>South Carolina</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Betty Carron</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or none)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>248-50-3935</u>		<u>Hospital Records</u>	
				<u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>1343</u> IMMEDIATE CAUSE (A) <u>Septicemia</u>							
ANTECEDENT CAUSE(S) DUE TO							
<u>Candida albicans (moniliasis)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Pulmonary abscess</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>11/14/59</u>				<u>Lung abscess</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		21d. HOW DID INJURY OCCUR?	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>11/11/59</u>, to <u>11/10/59</u>, that I last saw the deceased alive on <u>11/10/59</u>, and that death occurred at <u>9:03 PM</u>, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Wm. Newcomer, Superintendent, Mt. Wilson, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>11-13-59</u>		<u>W. F. M. Cemetery</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>NOV 17 '59</u>		<u>Arthur S. Krome</u>		<u>Frank H. Howell</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

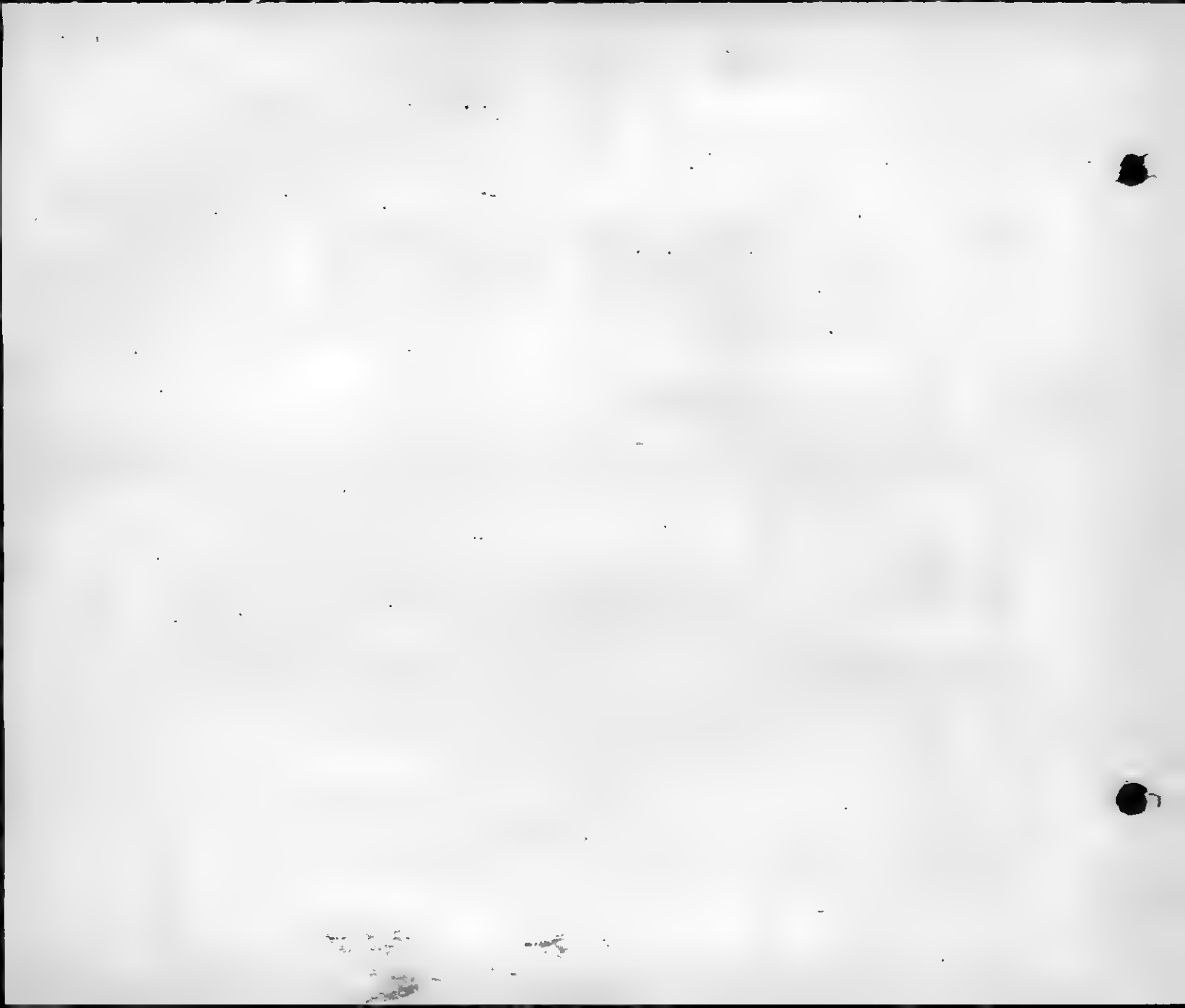
Reg. Dist. No.

12316

12335

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>ILLINOIS</i> b. COUNTY <i>DALLAS CITY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville Balto</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DALLAS CITY</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2929 Mann Ave.</i>		d. STREET ADDRESS <i>2929 Mann Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Myrtle Rose</i> First Middle Last		4. DATE OF DEATH <i>Nov. 25 1959</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 15 1882</i>
9. AGE (In years last birthday) <i>77</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dry Goods Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Illinois</i>	
11. BIRTH PLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Remain. Wood</i>		14. MOTHER'S MAIDEN NAME <i>Emma Tull</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>347-24-9910</i>	
17. INFORMANT <i>Daughter</i> Address <i>2929 Mann Ave Balto.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial degeneration</i> <i>170x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Marked cachexia</i> DUE TO (c) <i>Carcinomatosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>Mar 1959</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cc Breast - Radical mast left 1953</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April</i> , 1959, to <i>Nov</i> , 1959, that I last saw the deceased alive on <i>Nov 24</i> , 1959, and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>9005 Harford Rd. Balto</i> DATE SIGNED <i>11/25/59</i>			
ACTUAL SIGNATURE <i>Frank T. Kasik Jr.</i> M.D.		PHYSICIAN'S NAME (Type) <i>FRANK T. KASIK JR.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>11-27-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>DALLAS CITY</i>	22d. LOCATION (City, town, or county) (State) <i>DALLAS CITY ILLINOIS</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>CHAS. F. EVANS & SON</i> ADDRESS <i>8802 HARFORD RD.</i>		24a. REC'D BY REGISTRAR <i>NOV 27 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krasik</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12336

CERTIFICATE OF DEATH

Reg. Dist. No.

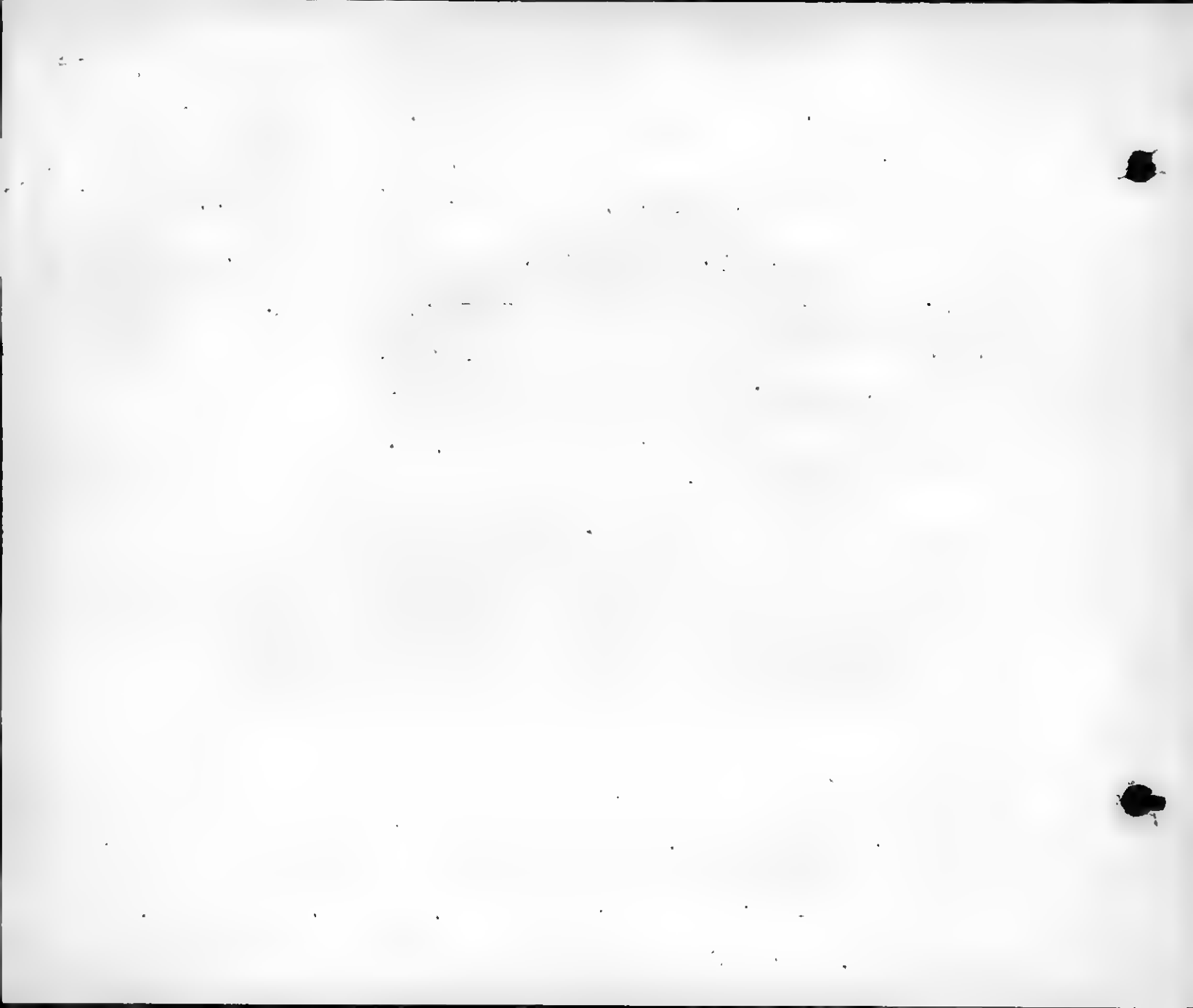
12317

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8104 Hillendale Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise G. (Lula) Roettger</u> Middle Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-25-1904</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Goodrich</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(if yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>217-20-6667</u>	
17. INFORMANT <u>Alroy L. Roettger</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive CVD.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>59</u> , to <u>Nov 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 10</u> , 19 <u>59</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph F. hi Pira</u> M.D.		ADDRESS (Street, city or town, state) <u>84 voluck Raven Rd. Balto 4, Md</u> DATE SIGNED <u>11/11/59</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH F. hi PIRA M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>11-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Hartford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the medical director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12337

CERTIFICATE OF DEATH

Reg. Dist. No.

12318

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AERO ACRES.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ROSEDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION IVY HALL.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ROHE Last ROHE		4. DATE OF DEATH Month NOV Day 28 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1860
9. AGE (In years last birthday) 99 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM. MILLER		14. MOTHER'S MAIDEN NAME MATHILDA UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE Address PETER ROHE KINGSVILLE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 Pulmonary edema DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 22, 1959 to Oct 27, 1959 that I last saw the deceased alive on Oct 27, 1959 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Samuel Stern M.D. M.D.			
PHYSICIAN'S NAME (Type) Samuel Stern, M.D. Ridge Road, Baltimore 6, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 1, 1959	
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD		22d. LOCATION (City, town, or county) (State) PARKVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James Funeral Home		24a. REC'D BY REGISTRAR DEC 4 '59	
ADDRESS 7401 Belair Road		24b. REGISTRAR'S SIGNATURE Charles L. Hines	



1

12338

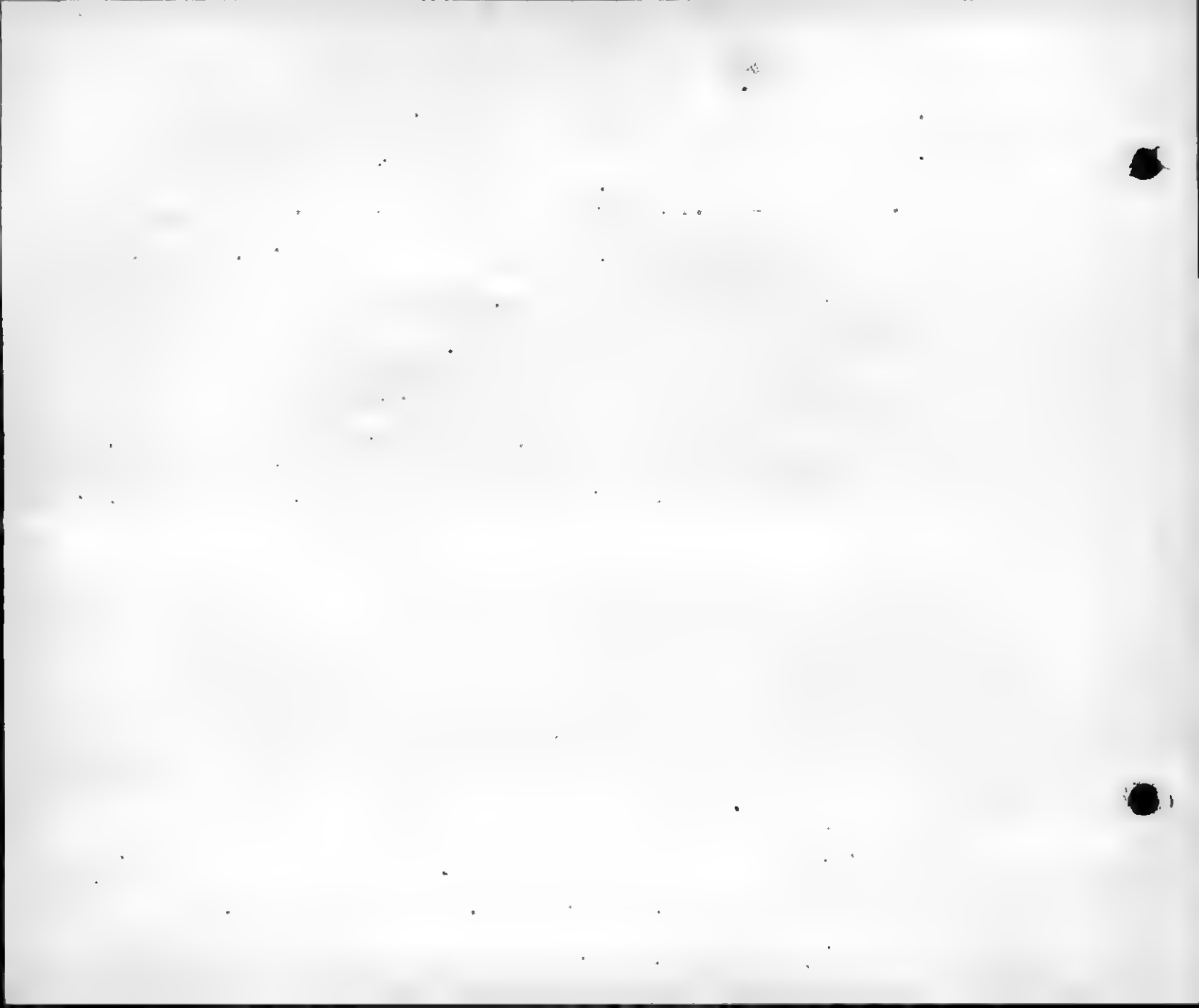
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12319

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Towson Nursing Home-301 W. Chesapeake Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Ex 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3008 Dubois Ave. #14 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAMIE Middle M. Last ROLAND		4. DATE OF DEATH Month Nov. Day 11, Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1876
9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 83	11. IF UNDER 24 HRS. Days 11	12. IF UNDER 24 HRS. Hours 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME John Wesley Spicer		14. MOTHER'S MAIDEN NAME Mary E. Kroh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Mrs. Verne Vandusen - 3008 Deboise Ave.		Address 3008 Deboise Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decompensative Cardio Vascular Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 25 , 19 59 , to Nov 11 , 19 59 , that I last saw the deceased alive on Nov 11 , 19 59 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd. Baltimore Md DATE SIGNED 12			
ACTUAL SIGNATURE Laurence C. Post		M.D. Baltimore Md	
PHYSICIAN'S NAME (Type) LAURENCE C. Post		Baltimore Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/14/59	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	22d. LOCATION (City, town, or county) Woodlawn, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Vickers & Sons - Balto. 17, Md		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12320

12339

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Professional House</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>-</u> Last <u>ROSENTHAL</u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>US 17</u>		13. FATHER'S NAME <u>Abraham Cronenberg</u>	
14. MOTHER'S MAIDEN NAME <u>Debrah</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>Samuel Rosenthal - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-Respiratory Failure</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Primary Adenocarcinoma of Lung</u> DUE TO <u>with milium metastasis to both lungs</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH 2, 1956</u> to <u>NOV 2, 1959</u> that I last saw the deceased alive on <u>NOV 2, 1959</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Willard E. Spengler, M.D.</u>		ADDRESS (Street, city or town, state) <u>5501 Park Heights Dr Baltimore Md</u>	
DATE SIGNED <u>11/6/59</u>		DATE	
PHYSICIAN'S NAME (Type)		22a. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	
22b. DATE THEREOF <u>11-4-59</u>	22c. LOCATION (City, town, or county) <u>Balto Md</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Kewer Inc</u>		24a. REC'D BY REGISTRAR <u>NOV 4 '59</u>	
ADDRESS <u>2100 Eustaw Place</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



12340

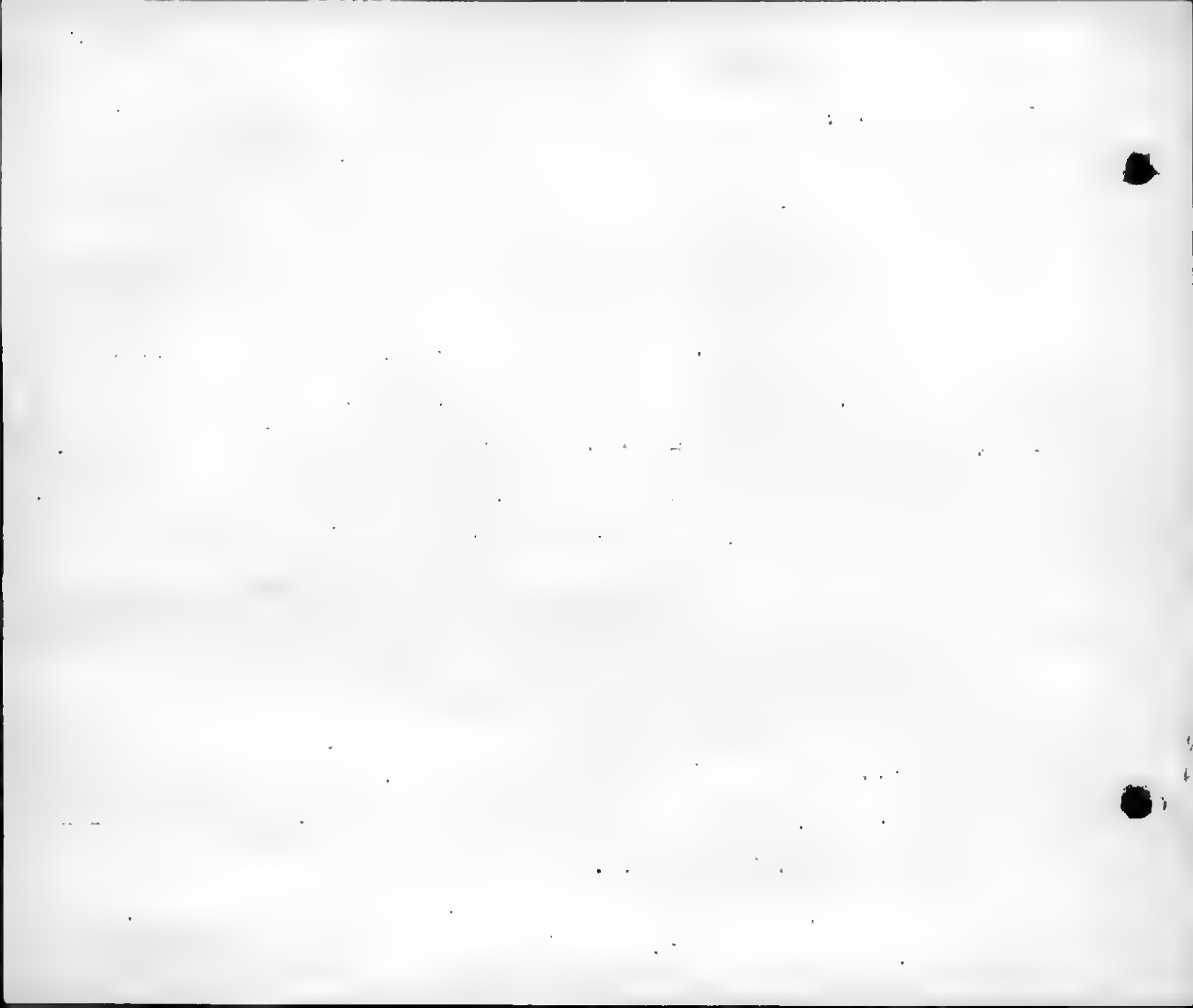
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>James G. Ross</u>		4. DATE OF DEATH Month Day Year <u>November 30, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 12, 1886</u>
9 AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11 BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John D. Ross</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Lynns</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO <u>212416-4021</u>		INFORMANT <u>Lrs. Margaret R. Crouse, 10624 Reisterstown Rd., Pikesville, Md.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 19, 1954</u> to <u>November 30, 1959</u> that I last saw the deceased alive on <u>Nov. 21, 1959</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>48 Main Street</u> <u>12-1-59</u>			
ACTUAL SIGNATURE <u>Martin E. Strobel</u> M.D.		DATE SIGNED <u>12-1-59</u>	
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel M.D.</u>		Reisterstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b DATE THEREOF <u>Dec. 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>	24b REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

12341

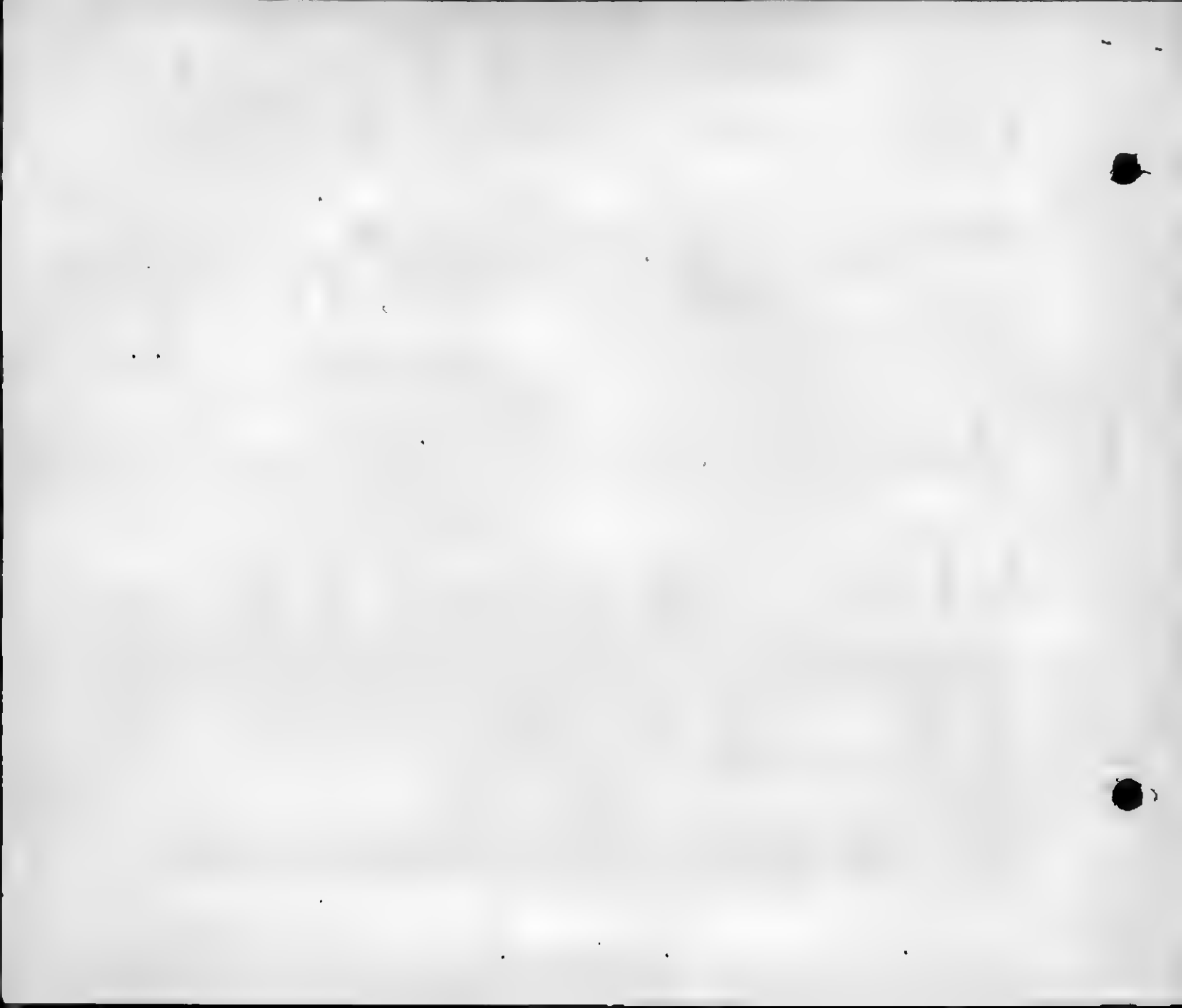
CERTIFICATE OF DEATH

Reg. Dist. No.

12322

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - rural</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armacott Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12, Md. 670 The Alameda</u> d. STREET ADDRESS <u>872 Register Ave. 3V-14</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Minna</u> Middle <u>E.</u> Last <u>Ross</u>				4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 18, 1871</u>		9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alexander Mathison</u>				14. MOTHER'S MAIDEN NAME <u>Mary Robinson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Mrs Mary D. Montague</u> Address _____					
18. CAUSE OF DEATH [Enter only one cause <u>pertaining</u> to (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Brain</u> <u>174x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Uterus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>24 Mths.</u> <u>5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____									
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Oct. 1948</u> , to <u>Nov 13, 1959</u> , that I last saw the deceased alive on <u>Nov 13, 1959</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7501 York Rd. Baltimore, Md.</u> DATE SIGNED <u>11/15/59</u> ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u> <u>Robinson #4 MD</u>									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>11/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore St.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlin & Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12323

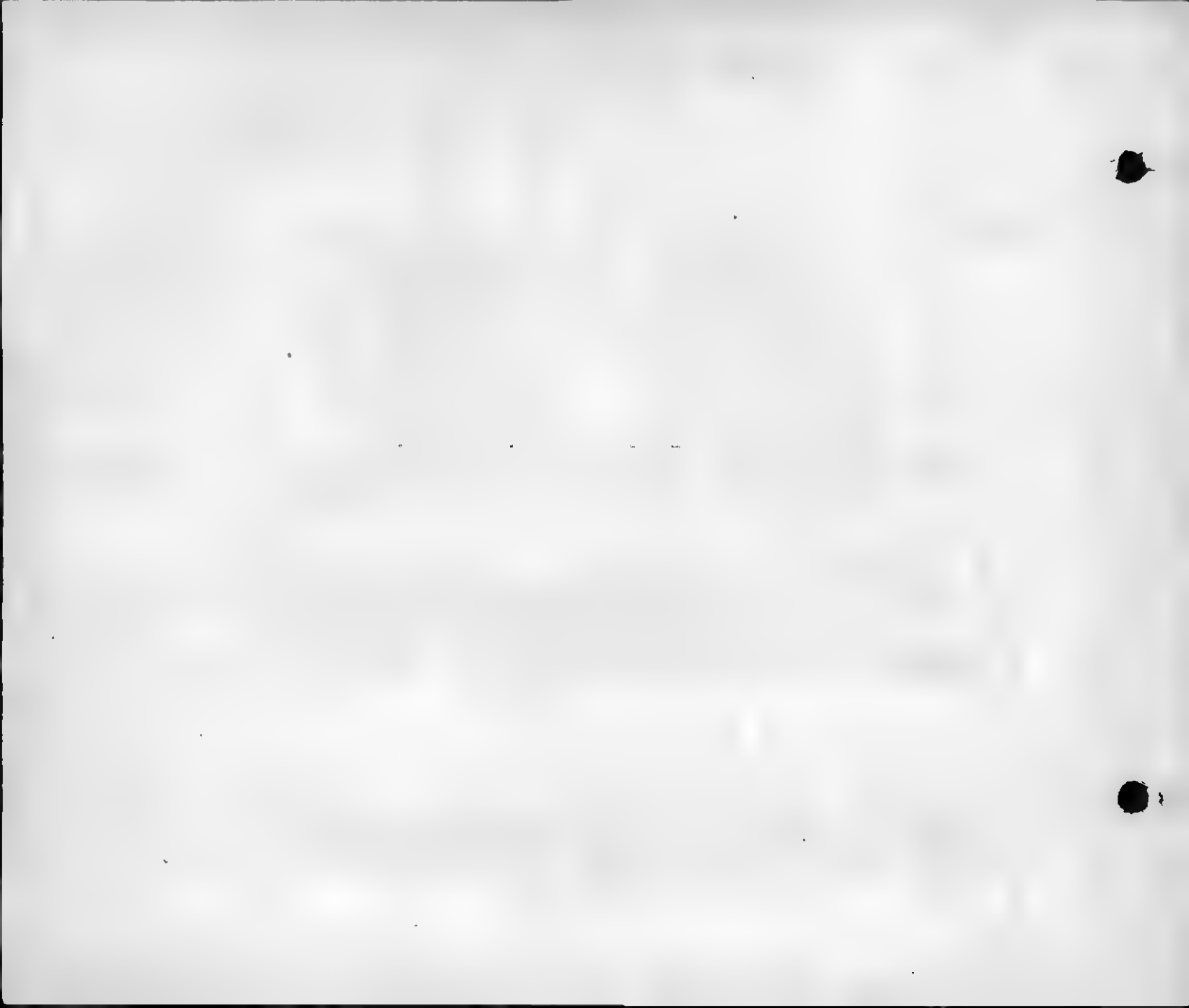
12342

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE MARYLAND. b. COUNTY BALT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point (19)				c. LENGTH OF STAY IN 1b 53 Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Inf.				e. STREET ADDRESS 3014 LIBERTY PARKWAY			
3. NAME OF DECEASED (Type or print) CHARLES First FRANCIS Middle RYAN, SR Last				4. DATE OF DEATH Month 11 Day 8 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1900		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Blast Furnace Steel				10b. KIND OF BUSINESS OR INDUSTRY Johnstown, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Micheal Ryan				14. MOTHER'S MAIDEN NAME Mary Russell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-07-0047		17. INFORMANT Mrs. Mary K. Ryan		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. DAVIS MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/59		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley				24a. REC'D BY REGISTRAR NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hanks	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12343

CERTIFICATE OF DEATH

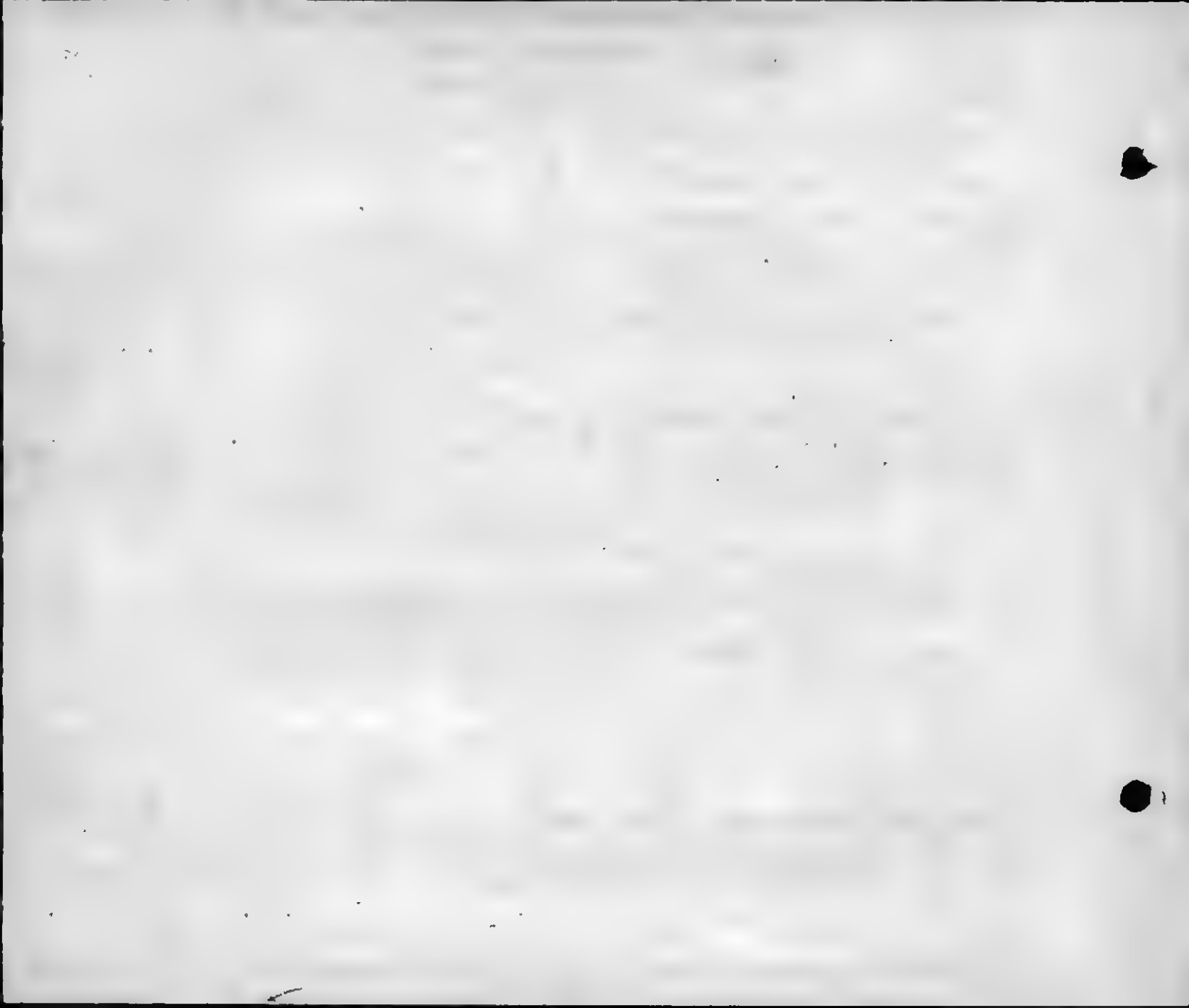
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Id b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		c. LENGTH OF STAY IN 1b 7 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Emory Rd.	
3 NAME OF DECEASED (Type or print) First Milton E. Middle Ryan Last		4. DATE OF DEATH Month November Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 00 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel M. Ryan		14. MOTHER'S MAIDEN NAME Margaret Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-05-7399	
17. INFORMANT Hilda M. Ryan		Address Emory Rd. Upperco, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral Insufficiency DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 19 48 to Nov 8, 19 59 , that I last saw the deceased alive on November 6, 19 59 , and that death occurred at 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Rd. Towson #4 Maryland DATE SIGNED 11/10/59			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		PHYSICIAN'S NAME (Type) Charles F. O'Donnell	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11-59	
22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		22d. LOCATION (City, town, or county) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank R. Seely		ADDRESS 814 W 36 St Balto "md"	
24a. REC'D BY REGISTRAR DATE NOV 12 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12345 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4 Washington Street (at work)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1914 N. Asquith St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle St Last STROSE		4. DATE OF DEATH Month November Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-19-1912
9. AGE (in years last birthday) 47 yrs.		10. UNDER 1 YEAR Months 11 Days 1	11. UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph St Rose		14. MOTHER'S MAIDEN NAME William St Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 1914 N Asquith St	
17. INFORMANT Lillian St Rose		Address 1914 N Asquith St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DU TO (c) DU TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		DATE SIGNED 11/3/59	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-7-59	22c. NAME OF CEMETERY OR CREMATORY Myrtlewood	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders		24a. REC'D BY REGISTRAR 217 E Preston	
24b. REGISTRAR'S SIGNATURE		DATE NOV 9 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 mo 7 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE 114 THE PINES</u>				e. STREET ADDRESS <u>190 COLUMBIA ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nora L Schlotterbeck</u>				4. DATE OF DEATH Month Day Year <u>11 21 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>0701X 31, 1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN, MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN PHILLIP SCHUELER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH DEATMERCK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIAM T. SCHLOTTERBECK, JR</u>		Address <u>ELLICOTT CITY, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemic Compensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>15 yr.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8-15-1959</u> to <u>11-21-1959</u> , that I last saw the deceased alive on <u>11-20-1959</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William K. Gallagher</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>11/21/59</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				M.D. <u>6209 Frederick Ave. Baltimore 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Perryer</u>				ADDRESS <u>HAGERSTOWN, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
				24c. REC'D BY REGISTRAR DATE <u>NOV 24 59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12347

12347

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12328

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7108 Campfield Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>SCHOENIJOHN</u> Last <u>A</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1905</u>
9. AGE (In years lost birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis H. Schoenijohn</u>		14. MOTHER'S MAIDEN NAME <u>Emeline Abellman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-03-2902</u>	
17. INFORMANT <u>Mr. Roy W. Kinstler - 7108 Campfield Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vaginal Hemorrhage</u> DUE TO (b) <u>Carcinoma of the Cervix</u> DUE TO (c) <u>6 months</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 12</u> 19 <u>59</u> to <u>Nov 30</u> 19 <u>59</u> that I last saw the deceased alive on <u>Nov 24</u> 19 <u>59</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas S. Bowyer</u> M.D.		ADDRESS (Street, city or town, state) <u>221 Med Arts Bldg</u>	
PHYSICIAN'S NAME (Type) <u>Thomas S. Bowyer</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Lickner & Sons - Route 17</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

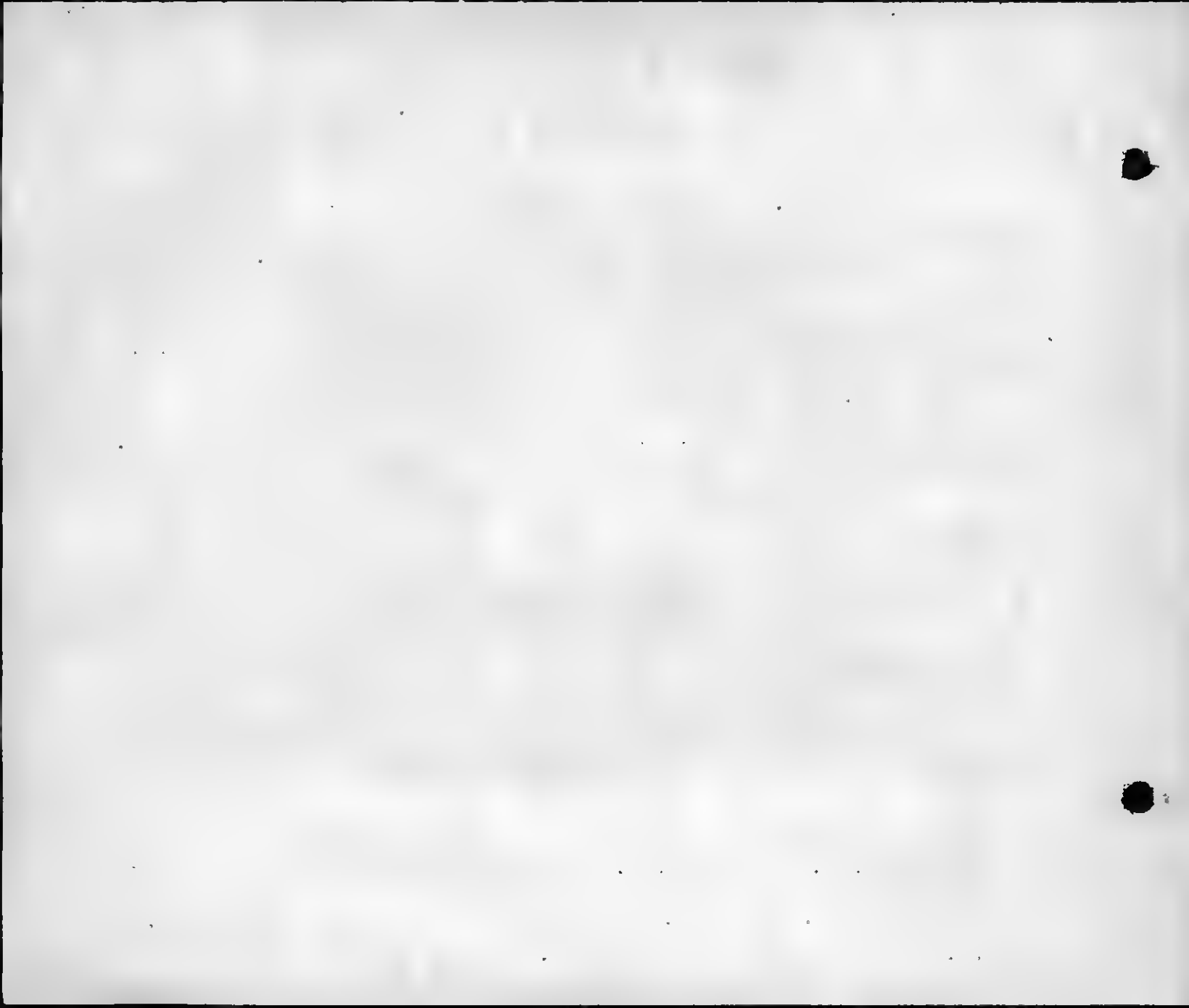
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Geroed Ave.</u>						/d. STREET ADDRESS <u>Geroed Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Thelma</u> Middle <u>E</u> Last <u>Shoemaker</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1899</u>		9. AGE (in years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Charles K. Demmitt</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Smallwood</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>218-18-9502</u>		17. INFORMANT Address <u>Elmer Shoemaker, Reisterstown, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> <u>none</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>none</u>		(County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>11-17-59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov. 19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Owings Mills, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons, Reisterstown, Md.</u>						24a. REC'D BY REGISTRAR <u>NOV 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. Eline</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

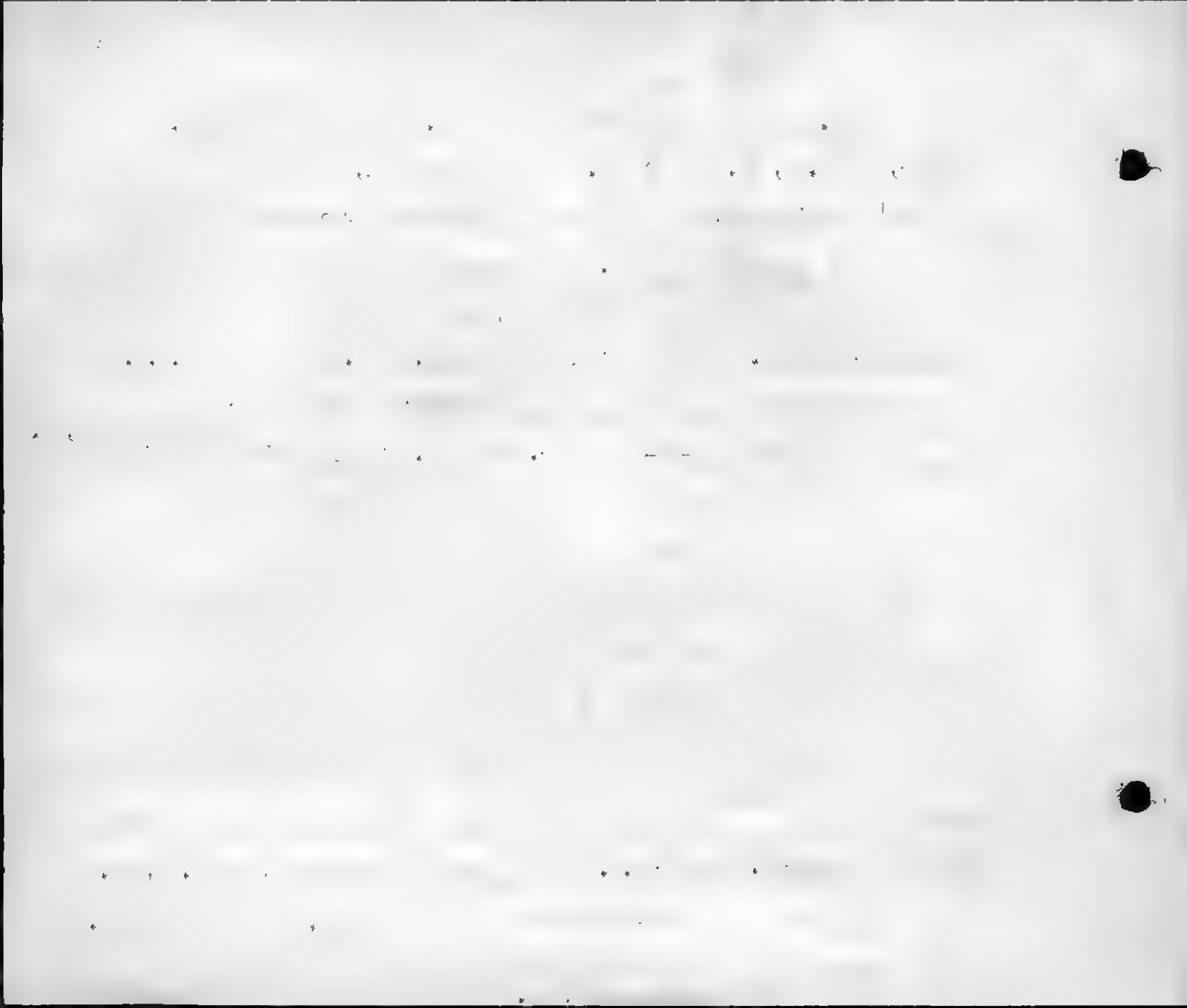
12348

CERTIFICATE OF DEATH

12329

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodmoor, Balto. 7, Md.		c. LENGTH OF STAY IN 1b 19 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Randallstown.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robb's Nursing Home				d. STREET ADDRESS 3603 Stoney Brook Road		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George E. Simpson		First Middle Last		4. DATE OF DEATH 11 22 19 59		Month Day Year	
5. SEX M		6. COLOR OR RACE W		7. DATE OF BIRTH 7/3/76		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Credit Dept.		10b. KIND OF BUSINESS OR INDUSTRY Loan & Finance		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Simpson				14. MOTHER'S MAIDEN NAME *Blanche Nancy Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-2236		17. INFORMANT Mr. Robert W. Simpson			
				Address Randallstown, Md. 3603 Stoney Brook Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44.3 X Acute Congestive Heart Failure DUE TO (b) Pulmonary edema + renal failure DUE TO (c) Chr. Cong. Heart Failure + Hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 10 days 10-12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 1, 1959 , to NOV. 22, 1959 , that I last saw the deceased alive on Nov. 22, 1959 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3601 Clifmar Road DATE SIGNED 11/22/59							
ACTUAL SIGNATURE Thomas E. Wheeler		M.D. 3601 Clifmar Road, Balto. 7, Md.					
PHYSICIAN'S NAME (Type) Thomas E. Wheeler M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Long Myers		ADDRESS 8728 Liberty Road		24a. REC'D BY REGISTRAR NOV 25 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	
		Randallstown, Md.					



12349

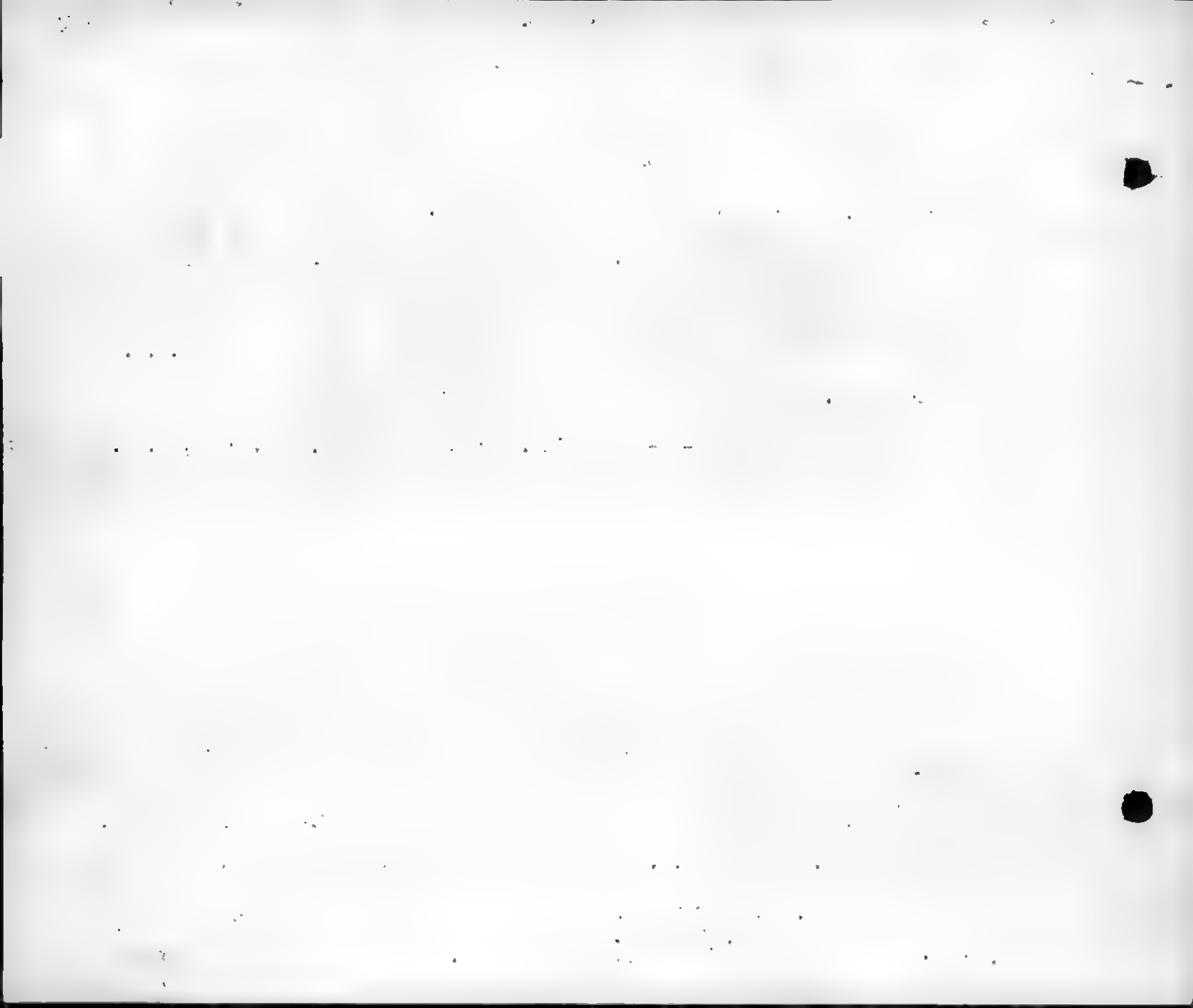
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c LENGTH OF STAY IN 1b 11 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 800 S. Broadway	
3. NAME OF DECEASED (Type or print) First EDWARD Middle H. Last SIRENS		4. DATE OF DEATH Month NOVEMBER Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 8/12/91
9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael J. Sirens		14. MOTHER'S MAIDEN NAME Mary Donovan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 212-12-5264	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 2, 1959 to November 13, 1959 and that death occurred at 6:05P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED DAH, BAL TO, 18, M.D. FORT HOWARD DIV.			
ACTUAL SIGNATURE David A. Oursler		M.D. DAH, BAL TO, 18, M.D. FORT HOWARD DIV.	
PHYSICIAN'S NAME (Type) DAVID A. OURSLER, M.D.		DAH, BAL TO, 18, MD, FORT HOWARD DIVISION 11/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 17 1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Noce		24a. REC'D BY REGISTRAR DATE NOV 16 59	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>1yr3mth5dys</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>6 Linden Terrace</u>			
				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marie Sisk</u>				4. DATE OF DEATH Month Day Year <u>November 20 1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1885</u>	
				9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Gore</u>				14. MOTHER'S MAIDEN NAME <u>Stella Crawford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>214-24-2623</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> 570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Volvulus of sigmoid colon</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile brain disease.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 14, 1958</u> , to <u>Nov. 20, 1959</u> , that I last saw the deceased alive on <u>Nov. 20, 1959</u> , and that death occurred at <u>1:00 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 11-20-59</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>				ADDRESS <u>4905 York Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 23 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>William L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12351

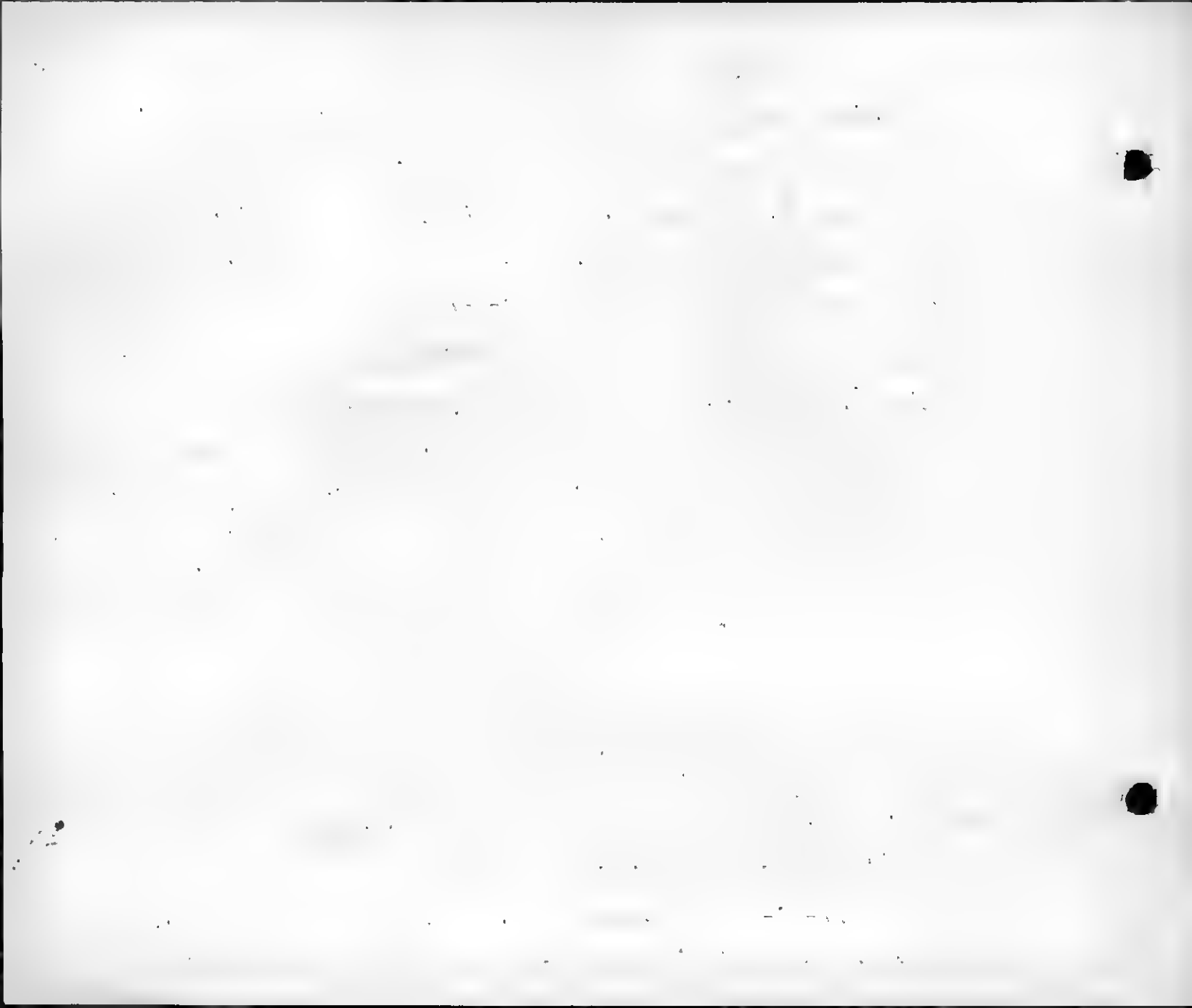
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1603 Providence Rd.</u>				e. STREET ADDRESS <u>1603 Providence Rd.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>B.</u> Last <u>Sisson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-1907</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William E. Grueninger</u>				14. MOTHER'S MAIDEN NAME <u>Carolina Lovis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		INFORMANT <u>Louis J. Sisson</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction, complete</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Carcinoma ovary, recurrent, metastatic, intraabdominal</u> DUE TO (c) <u>8 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1959</u> , to <u>Aug. 26, 1959</u> , that I last saw the deceased alive on <u>Aug. 26, 1959</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Mitchell H. Miller</u>		M.D. <u>600 W. Belvedere Avenue #10</u>		DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Mitchell H. Miller, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd</u>		24a. REGISTERED REGISTRAR DATE <u>NOV 12 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Res'dence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 316 MARGARET AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN SLEPPY				4. DATE OF DEATH Month Day Year NOV 8 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 7-1910	
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10b. KIND OF BUSINESS OR INDUSTRY EASTERN S. STEEL			
11. BIRTHPLACE (State or foreign country) PENNA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME KENNETH D. SLEPPY				14. MOTHER'S MAIDEN NAME NELLIE COLLINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-18-6054			
17. INFORMANT Address HALEN SLEPPY-316 MARGARET AVE							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11/8 1959				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/8 1959 to 11/8 1959 , that I last saw the deceased alive on 11/8 1959 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Platt M.D.				ADDRESS (Street, city or town, state) 434 Eastern Ave DATE SIGNED 11/9/59			
PHYSICIAN'S NAME (Type) J. PLATT M.D.				Easly MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV-11-1959		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) BALTO. Co. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connolly ADDRESS 418 Eastern Ave East Md				24a. REC'D BY REGISTRAR NOV 12 1959		24b. REGISTRAR'S SIGNATURE John S. Connolly	

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12353

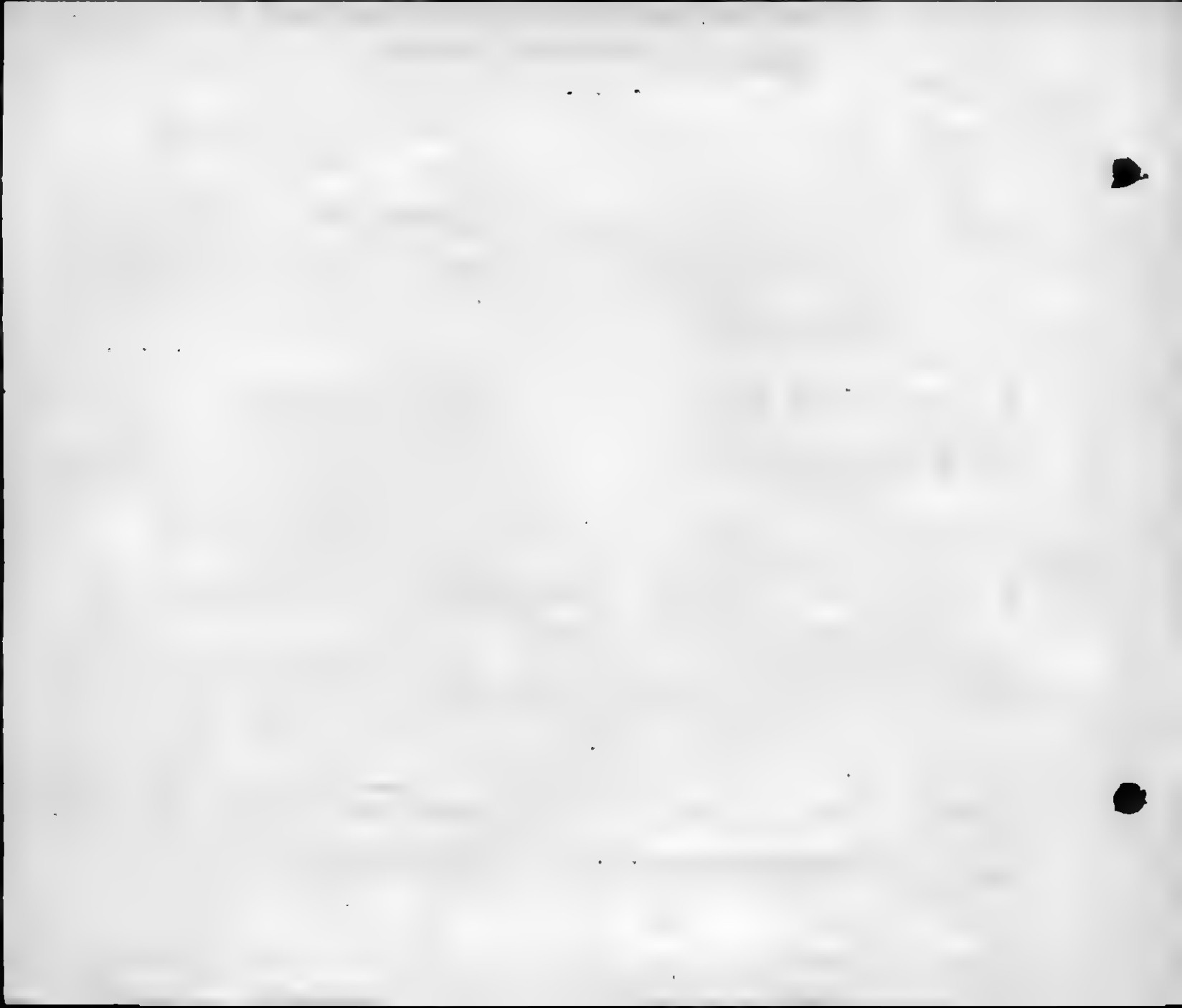
CERTIFICATE OF DEATH

12334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Last Smith		4. DATE OF DEATH Month November Day 25 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1879
9. AGE (In years last birthday) yrs. 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME XXXXXX Henry Kornmann		14. MOTHER'S MAIDEN NAME XXXXXX Emma Sweitzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral and generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 24 , 19 59 , to November 25 , 19 59 , that I last saw the deceased alive on Nov. 25 , 19 59 , and that death occurred at 1:45 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Siropoulos		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-25-59	
PHYSICIAN'S NAME (Type) Aristide Siropoulos, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/28/59	22c. NAME OF CEMETERY OR CREMATORY Baltimore cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE A. Sander & Sons Inc.		ADDRESS 1111 North & Broadway	
24a. REC'D BY REGISTRAR NOV 30 1959		24b. REGISTRAR'S SIGNATURE E. L. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



X 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

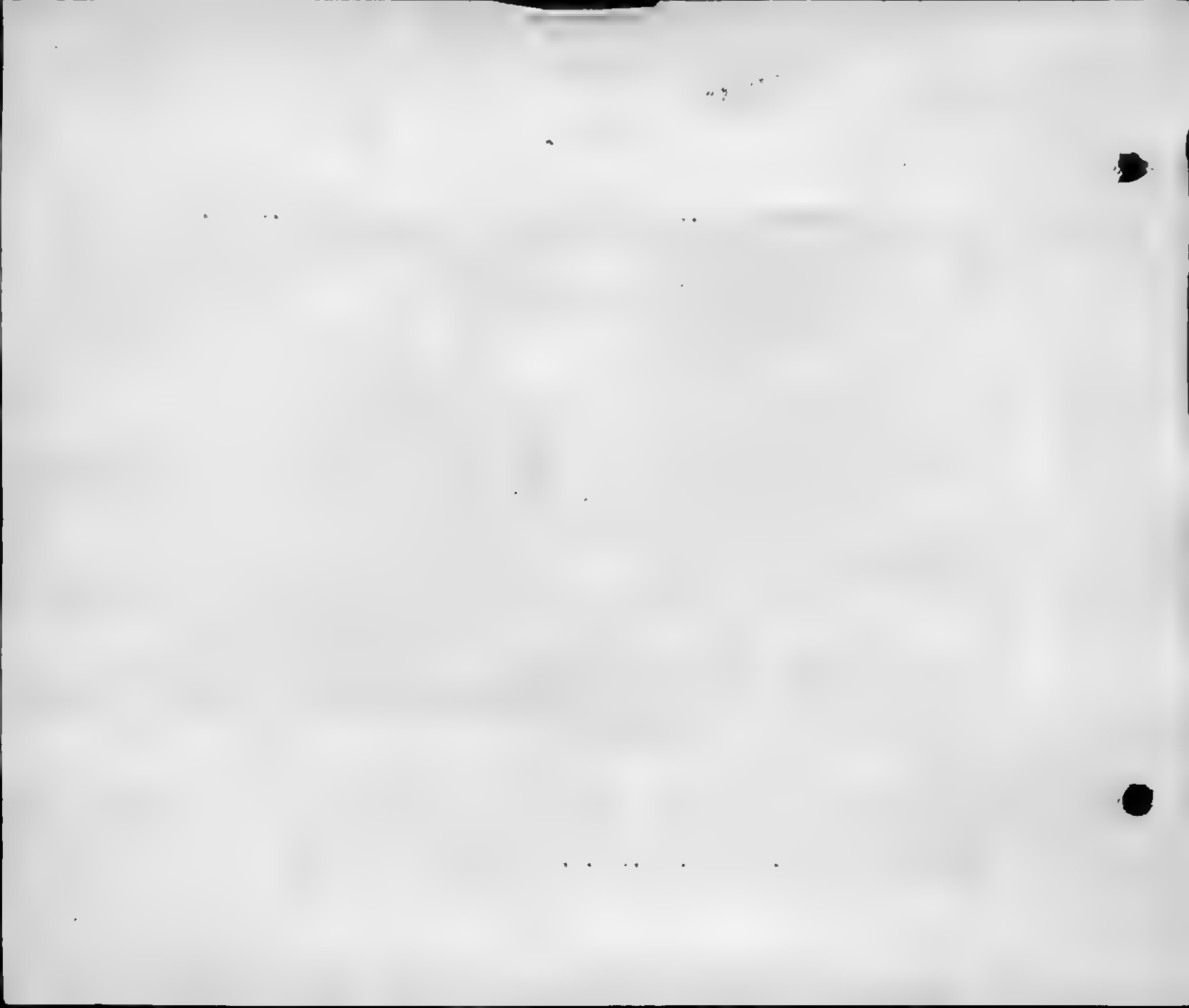
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12336

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4415 Washington Blvd., Trailer Camp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5605 Haddon Ave., Apt. B</u>					
3. NAME OF DECEASED (Type or print) <u>HENRY SMITH</u>		4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1959</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					
8. DATE OF BIRTH <u>3-13-1916</u>		9. AGE (In years last birthday) <u>43</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Hours</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Hours	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS								
Months	Hours								
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salvage</u>					
13. FATHER'S NAME <u>Louis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Smith</u>		Address <u>- Same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>									
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Herring Run</u>					
22d. LOCATION (City, town, or country) <u>Balto</u>		(State) <u>Md</u>		23. FUNERAL DIRECTOR <u>Jack Lewison</u>					
ADDRESS <u>2100 Lutan Pl</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>					
DATE <u>NOV 13 '59</u>									

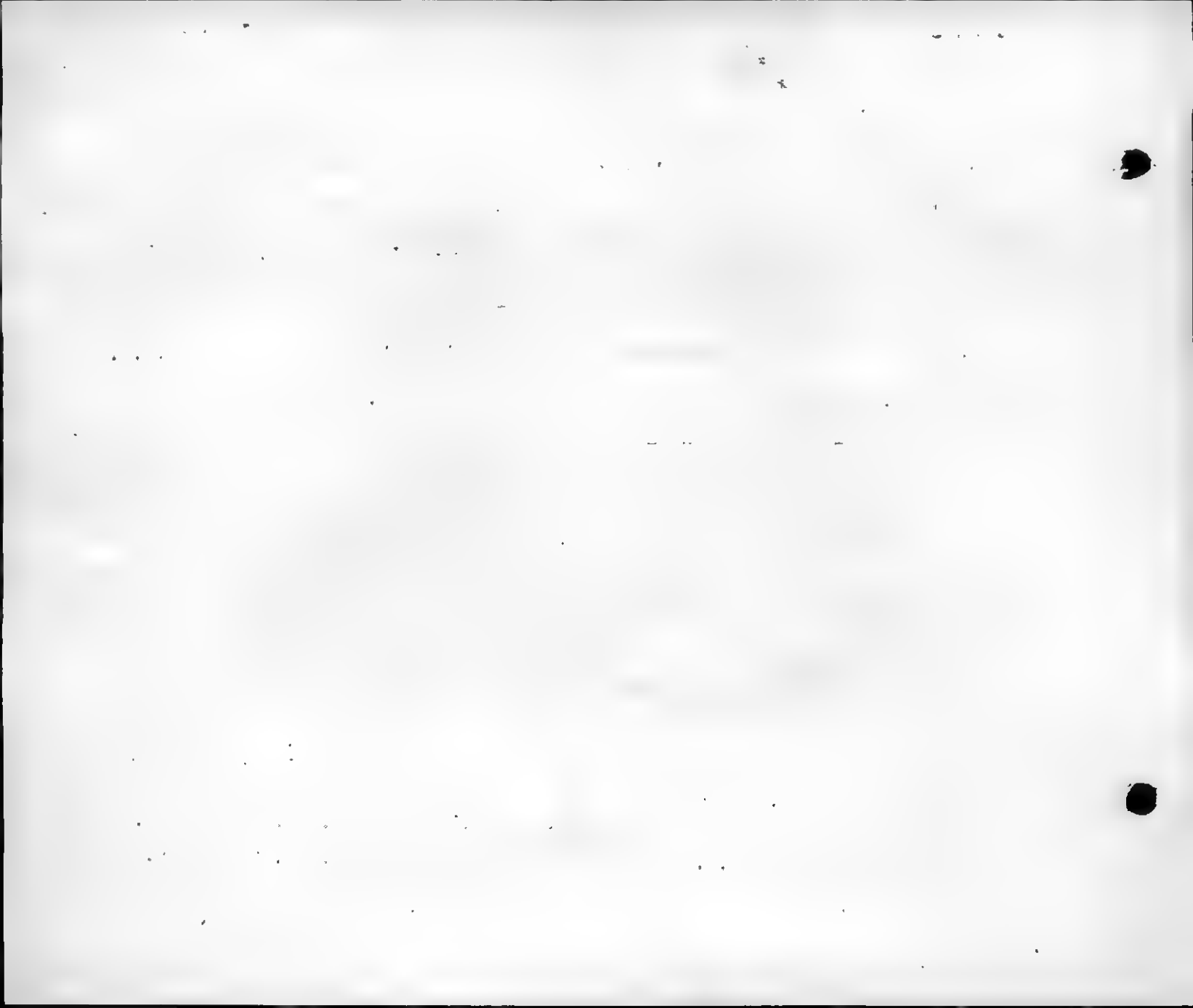


12354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 43 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTH LINTHICUM		d. STREET ADDRESS 9 LAKEFRONT DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY HARRIS SMITH Sr. (Served as: HARRY HARRIS SMITH)		4. DATE OF DEATH Month NOVEMBER Day 14 Year 19 59		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-7-1900	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min 59		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSMAN		10b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry H. SMITH		14. MOTHER'S MAIDEN NAME Margaret J. White		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. 213-03-2401		INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMATEMESIS 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESOPHAGEAL VARICIES DUE TO (c) CIRRHOSIS OF THE LIVER										INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that VA attended the deceased from October 2 , 19 59 , to November 14 , 19 59 , and that death occurred at 3:55 p.m. , from the causes and on the date stated above. DATE 11/15/59 and that death occurred at 3:55 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO 18, MD. FT. HOWARD DIV. DATE SIGNED 11/15/59											
ACTUAL SIGNATURE Paul Bormel		PHYSICIAN'S NAME (Type) PAUL BORMEL, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/18/59		22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PARK		22d. LOCATION (City, town, or county) BALTIMORE MARYLAND		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Wm J Tickner & Sons Inc		ADDRESS North & Pennsylvania Ave		24a. REC'D BY REGISTRAR NOV 16 59		24b. REGISTRAR'S SIGNATURE James E. Hays					
Baltimore Md.											



12355

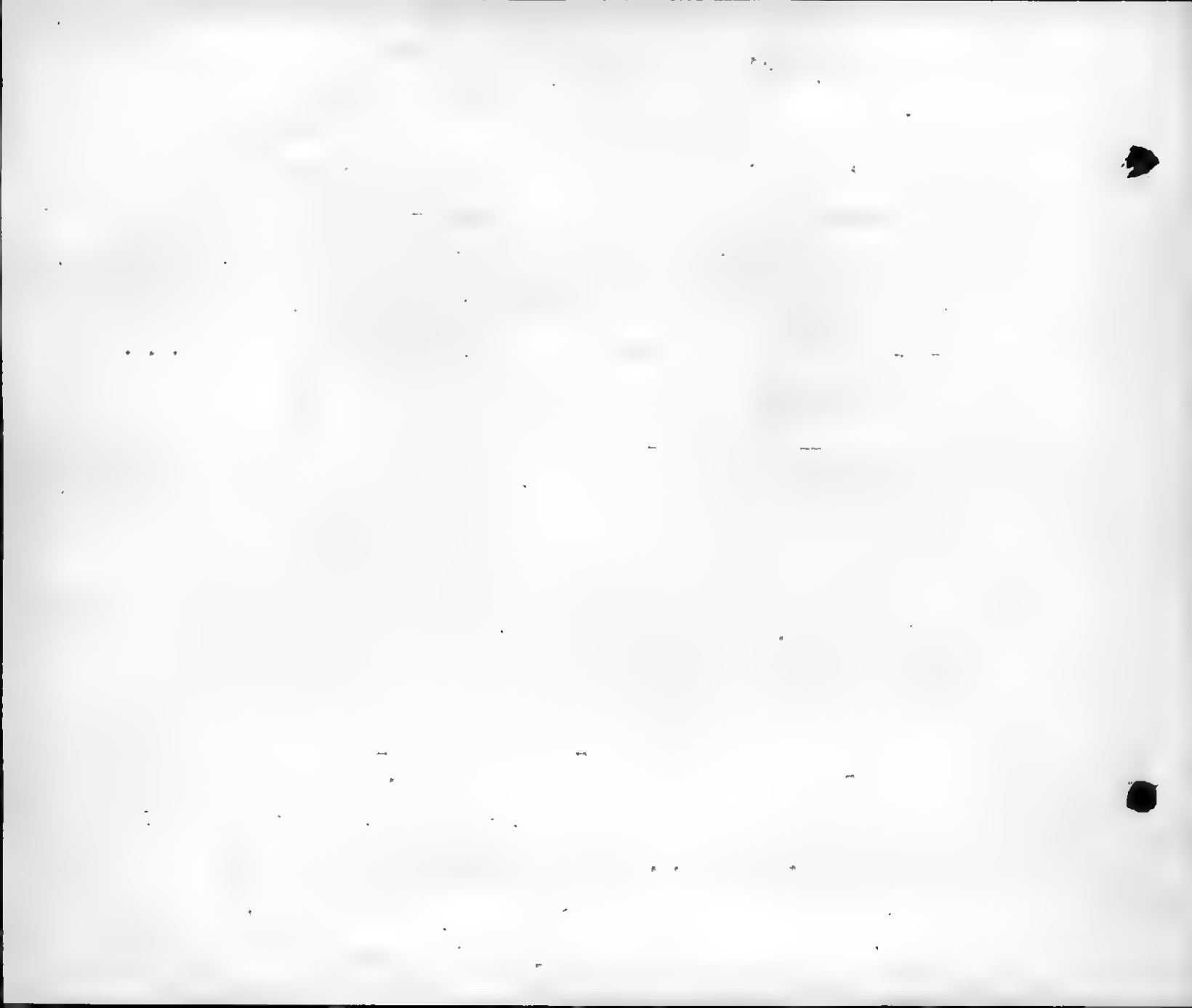
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN 1b <u>2 MONTHS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro, Maryland</u> d. STREET ADDRESS <u>Route 2 - Box 178</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norvel Robert Smith</u>		4. DATE OF DEATH Month Day Year <u>11 20 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/58</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Robert Smith</u>		14. MOTHER'S MAIDEN NAME <u>Rose Marie Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Rosewood Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonitis</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Meningitis in Oct. 1959; Hydrocephalus congenital</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-16-</u> 19 <u>59</u> to <u>11-20</u> 19 <u>59</u> that I last saw the deceased alive on <u>11-19</u> 19 <u>59</u> , and that death occurred at <u>4:15 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. Rosewood State Training School</u> DATE SIGNED <u>11/20/59</u>			
ACTUAL SIGNATURE <u>Viola B. Johns</u>		M.D. <u>Rosewood State Training School</u> <u>11/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Viola B. Johns, M.D.</u>		<u>Owings Mills, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookes Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Knotttingham Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George E. Nelson</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>	
ADDRESS <u>3489 Calhoun St</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12338

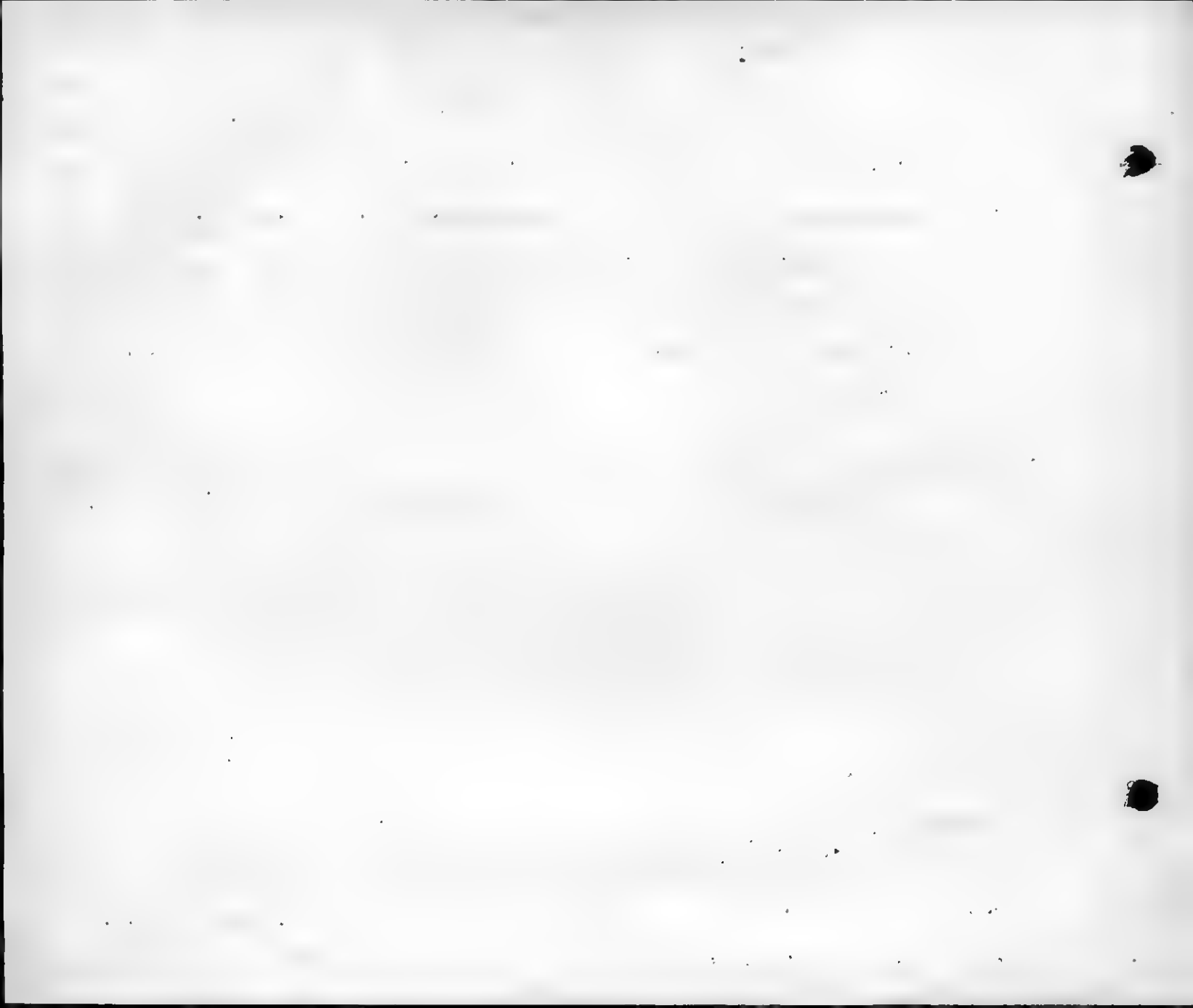
12356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Overlea c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6802 Beech Avenue				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Overlea d. STREET ADDRESS 6802 Beech Ave. Balto. 6, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Cecelia Snyder				4. DATE OF DEATH Month 11 Day 26 Year 1959							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/19/1880		9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79 Days 26 Hours 15 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Snyder						14. MOTHER'S MAIDEN NAME Mary Tremper					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		INFORMANT Emma Dresch 6802 Beech Avenue #6				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x Cerebral arteriosclerosis DUE TO (b) Syn Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Oct 24, 1959 to Nov 13, 1959 that I last saw the deceased alive on Nov 24, 1959 and that death occurred at 10:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1W. OVERLEA AVE BALTO 6 Md DATE SIGNED											
ACTUAL SIGNATURE DR. RIGLER				PHYSICIAN'S NAME (Type) DR. RIGLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/28/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer				22d. LOCATION (City, town, or county) Balto. City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Funeral Home 7401 Belair Rd						24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hagedorn			

TO HOSPITAL OR A FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.,				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto., Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Joppa Road				d STREET ADDRESS 26 E. Joppa Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Joseph Middle Snyder Last Snyder				4. DATE OF DEATH Month November Day 11 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-71	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88		IF UNDER 24 HRS. Days 88 Hours 88 Min. 88			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Snyder				14. MOTHER'S MAIDEN NAME Mary Tremper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 213-40-0390		17. INFORMANT Catherine Snyder Address 26 E. Joppa Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis, generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 4 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 7, 1959 to November 11, 1959 that I last saw the deceased alive on November 10, 1959 and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Theodore E. Evans M.D. Perry Hall Medical Group PHYSICIAN'S NAME (Type) Theodore E. Evans November 11, 1959							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-59		22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassam J. J. Jones ADDRESS 7401 Belair Rd.				24a. REC'D BY REGISTRAR DATE NOV 16 1959		24b. REGISTRAR'S SIGNATURE Charles E. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12340

Reg. Dist. No.

12358

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Martin Co.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1219 Glenwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>W.</u> Last <u>Spear</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>19 59</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-1910</u>		9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Airplane</u>				11. BIRTHPLACE (State or foreign country) <u>Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel W. Spear</u>						14. MOTHER'S MAIDEN NAME <u>Daisey Young</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT <u>Elizabeth A. Spear</u> Address <u>same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
EXAMINER'S SIGNATURE <u>M. B. Davis</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>11/26/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>11-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>						ADDRESS <u>5305 Harford Rd</u>				24a. REC'D BY REGISTRAR <u>DATE NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford S. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12202

CERTIFICATE OF DEATH

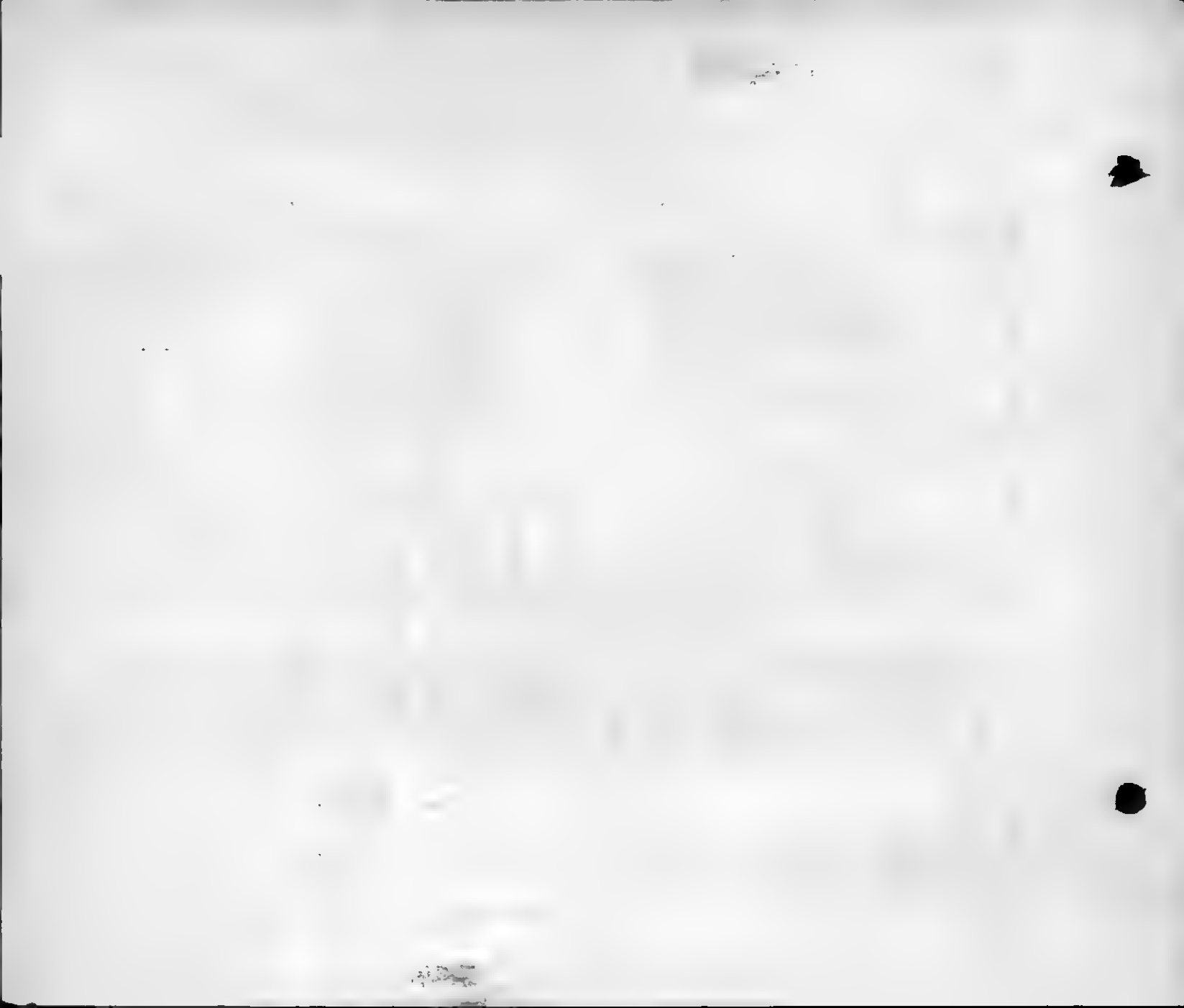
Reg. Dist. No.

12341

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 56 S. Dundalk Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CONRAD Middle J. Last STEINBACH		4. DATE OF DEATH Month November Day 22 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-Ret.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferdinand Steinbach		14. MOTHER'S MAIDEN NAME Louise Brettschneider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Mrs. Sal y Steinbach, 56 S. Dundalk Ave-22	
17. INFORMANT Mrs. Sal y Steinbach, 56 S. Dundalk Ave-22		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Chronic bronchiectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lung abscess. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 8 months 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 19 59 , to NOV. 22 , 19 59 , that I last saw the deceased alive on NOV. 21 , 19 59 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David H. Andrew M.D.		ADDRESS (Street, city or town, state) 33 Dundalk Ave DATE SIGNED Dundalk Md.	
PHYSICIAN'S NAME (Type) David H. Andrew			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/26/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR NOV 27 59 24b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 X
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest c. LENGTH OF STAY IN 1b Lodge Forest d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7309 Waldman Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest d. STREET ADDRESS 7309 Waldman Ave. e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA First Middle Last S. STEPHENS		4. DATE OF DEATH Month Day Year November 8, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1894 9. AGE (In years last birthday) 65 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Penna	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Walters		14. MOTHER'S MAIDEN NAME Johannah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO No.	
17. INFORMANT Mrs. Wm. H. Dawson		Address 7309 Waldman Ave-19	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) A-S-C-V-Disease (c) A-S-C-V-Disease DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		DATE SIGNED 11/8/59	
EXAMINER'S NAME (Type) M. B. DAVIS M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/11/59	22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	22d. LOCATION (City, town, or county) (State) Johnstown, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR NOV 10 1959	
ADDRESS 4107 Wilkens Avenue		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first of these is the fact that the

1. The first of these is the fact that the

12360

CERTIFICATE OF DEATH

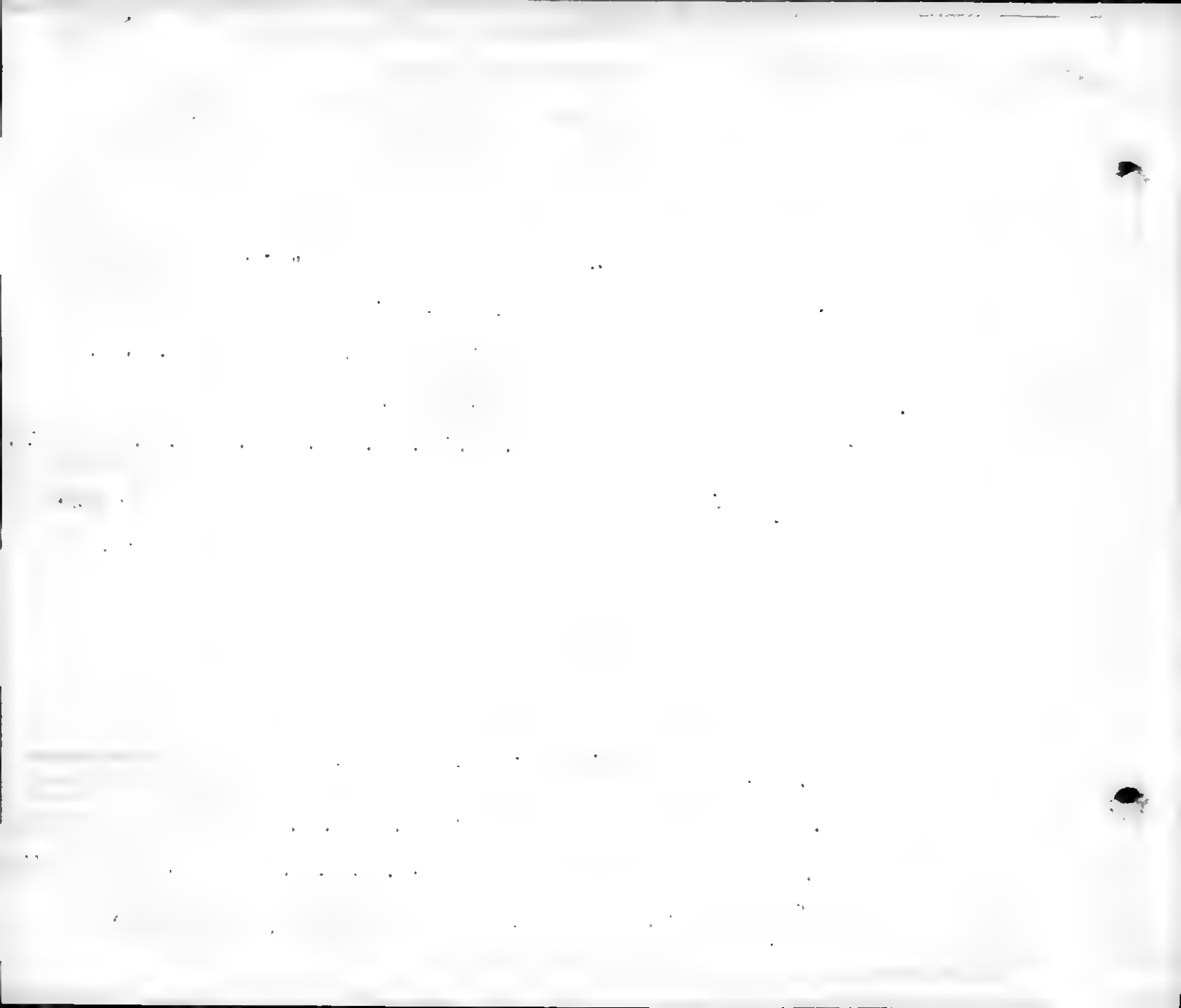
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor		d. STREET ADDRESS 15 Glenwood Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PHILIPPINA STEVERNAGEL First Middle Last		4. DATE OF DEATH Nov. 17 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/74
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. LSJAC OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ind.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Rebert		14. MOTHER'S MAIDEN NAME Martha Pittman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Yes, give war or dates of service)		16. SOCIAL SECURITY NO. George Steuermann	
17. INFORMANT George Steuermann		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis ILLUX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ARTERIO SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 8-12-59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-12-1959 to Nov. 15 1959 , that I last saw the deceased alive on Nov. 15 1959 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1326 W. LOVIBARD ST. BALTO. MD. DATE SIGNED Nov. 18, 1959			
ACTUAL SIGNATURE Carl Proetling M.D.		PHYSICIAN'S NAME (Type) CARL PROETLING, M.D.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/59	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. McArthur + Son		ADDRESS 28	
24a. REC'D BY REGISTRAR NOV 23 '59		24b. REGISTRAR'S SIGNATURE Charles J. Kiser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained to be filed in hospital or attending physician's file.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 12362 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowleys Quarters, Md.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowleys Quarters, Md.</u>		c. LENGTH OF STAY IN 1b <u>242 Bay Drive</u>		d. STREET ADDRESS <u>242 Bay Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>242 Bay Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Medford Getz Talbott</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1959</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
8. DATE OF BIRTH <u>1-29-1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufact. Rep.</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY <u>USA</u>			
14. FATHER'S NAME <u>Charles Talbott</u>			15. MOTHER'S MARRIED NAME <u>Margaret Getz</u>				
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		17. SOCIAL SECURITY NO. <u>213-05-6349</u>		18. INFORMANT <u>Julia I. Talbott</u> Address <u>same</u>			
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> 4:00 P.M. DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>A-S-C-V-Disease</u> (c), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
21c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State)			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/23/59</u>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/25/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Rd</u>				ADDRESS			

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12363

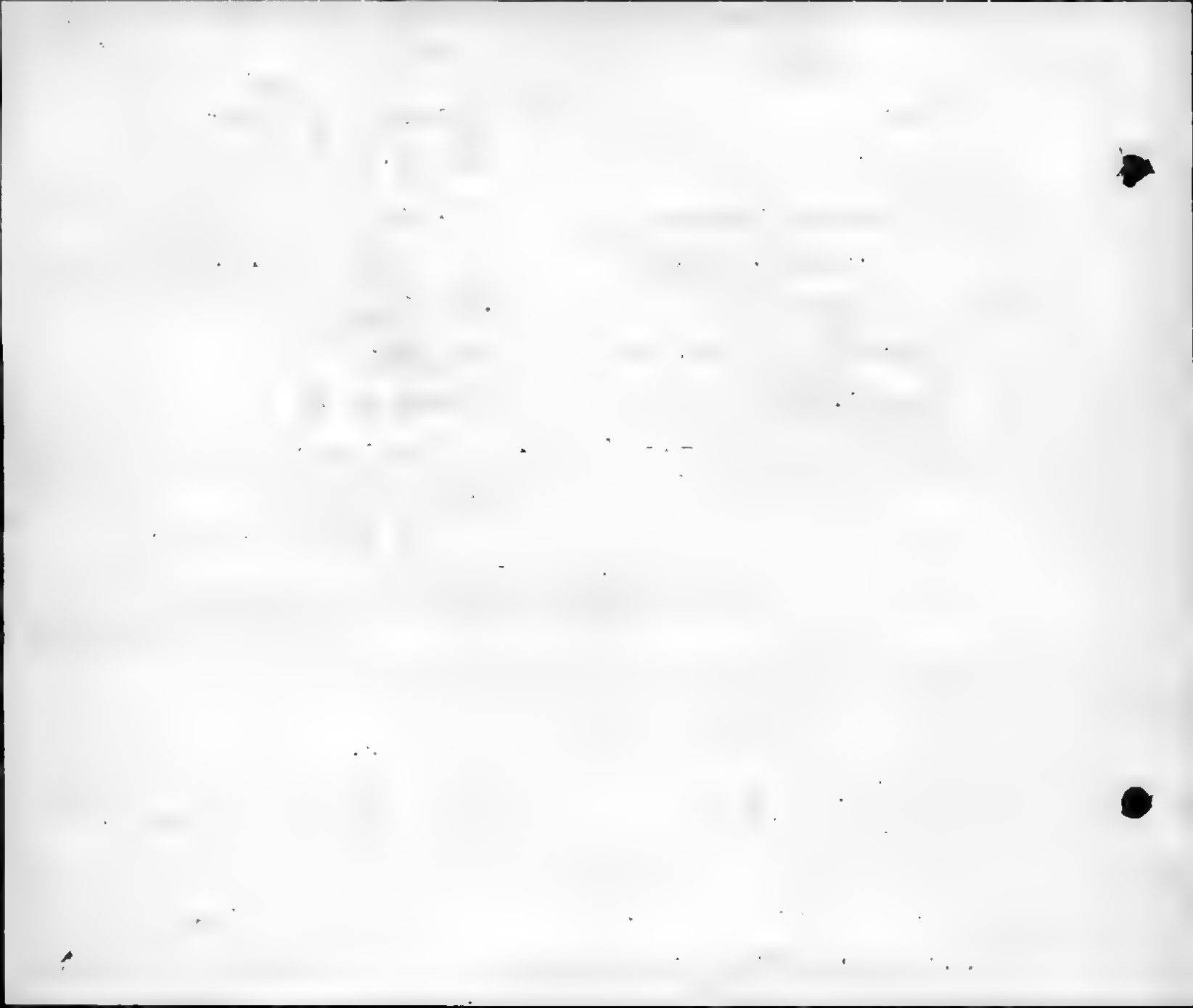
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM E. TALBOTT First Middle Last				4. DATE OF DEATH Nov. 22, 1959 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 13, 1883	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Monrovia, Md		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farm Owner			
13. FATHER'S NAME George E. Talbott				14. MOTHER'S MAIDEN NAME Georgia Gaither			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-34-3027		INFORMANT Mrs. Lenore Talbott, Clarksville, Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis (c) Hypocalcemia							INTERVAL BETWEEN ONSET AND DEATH 1 hr upon Skulls
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov - 1, 1959 to Nov - 22, 1959 that I last saw the deceased alive on Nov - 20, 1959 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wetherbee Fort M.D.				ADDRESS (Street, city or town, state) 6 Sutton Ave. Belts. 38 DATE SIGNED Dec. 30			
PHYSICIAN'S NAME (Type) Wetherbee Fort							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-59		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham ADDRESS Ellicott City, Md				24a. REC'D BY REGISTRAR NOV 27 '59 DATE		24b. REGISTRAR'S SIGNATURE Wm. S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12364

CERTIFICATE OF DEATH

See Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Dr. Benjamin Tappan Sr.</i>			2. DATE OF DEATH <i>11/30/59</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>6904 Bellona Ave</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BALTIMORE</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>BALTIMORE COUNTY</i> <i>6904 Bellona Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>X</i> <i>Baltimore</i>		
c. Length of stay in Baltimore <i>55 yrs</i>			D. STREET ADDRESS (If rural, give location) <i>6904 Bellona Ave.</i>		
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i>	8. DATE OF BIRTH <i>March 9, 1890</i>	9. AGE (In years last birthday) <i>69</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chiropractor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		11. BIRTHPLACE (State or foreign country) <i>Rochester, N. Y.</i>	
13. FATHER'S NAME <i>William Tappan</i>			14. MOTHER'S MAIDEN NAME <i>Sarah E. Buchanan</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs Edna Keyser Tappan</i>	
				ADDRESS <i>Balt, 12</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>++ !</i>		CAUSE OF DEATH <i>UNKNOWN</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1.5 hr</i>	
ANTECEDENT CAUSES		(A) DUE TO <i>Acute</i>		(B) DUE TO <i>Acute</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO <i>Cerebral arteriosclerosis</i>		(D) DUE TO <i>6 hr</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Cerebral arteriosclerosis</i>		<i>1 hr</i>	

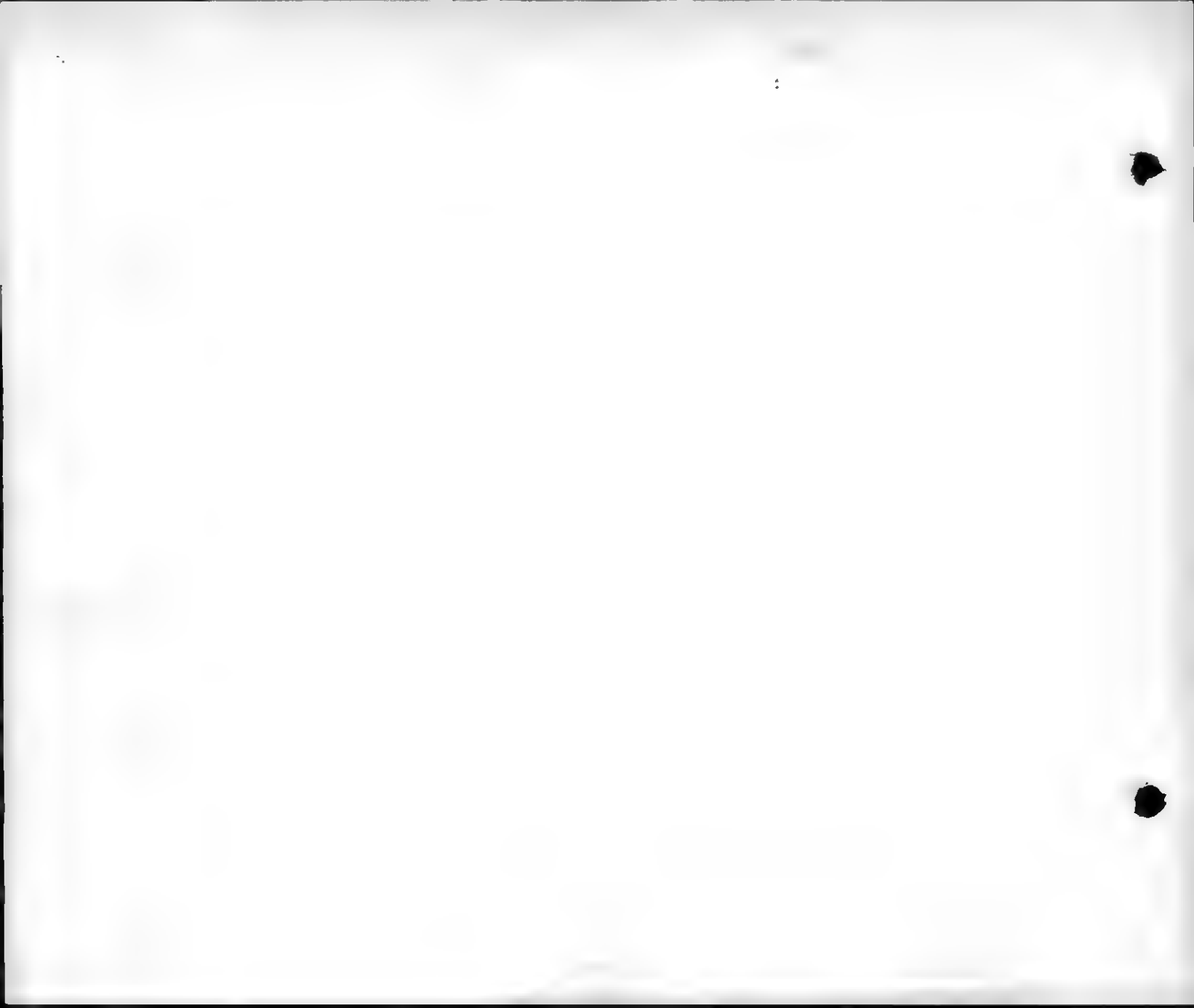
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
OF INJURY		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		INJURY OCCURRED			

22. I certify that (I) (this hospital) attended the deceased from 1959 to 1959, that (I) (we) last saw the deceased alive on 11/27/59, and that death occurred at 11/30/59, from the causes and on the date stated above.

23A. SIGNATURE <i>William A. Fitch</i>		23B. ADDRESS <i>20 University Park</i>		23C. DATE SIGNED <i>12-1-59</i>	
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		M.D.			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>12/2/59</i>		24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Balt. Md</i>		24E. LOCATION (City, town, or county) (State) <i>Balt. Md</i>		24F. LOCATION (City, town, or county) (State) <i>Balt. Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 2 1959</i>		REGISTRAR'S SIGNATURE <i>Arthur J. Fitch</i>		25. FUNERAL DIRECTOR <i>Loring Byers</i>	
				ADDRESS <i>8728 Liberty Road</i>	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 18-21, Film 222 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12348

<p>1. PLACE OF DEATH 12365</p> <p>a. COUNTY Baltimore MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard</p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fort Howard Hospital</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE Maryland b. COUNTY Kent</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall</p> <p>d. STREET ADDRESS</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print)</p> <p>JOHN C. THOMPSON</p>		<p>4. DATE OF DEATH</p> <p>November 8, 1959</p>		<p>5. SEX Male</p>			
<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH Oct. 14 - 1924</p>			
<p>9. AGE (In years last birthday) 35 yrs.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER</p>		<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>			
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		<p>13. FATHER'S NAME Jewell Thompson</p>		<p>14. MOTHER'S MAIDEN NAME Edith Warner</p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES W.W. # 2</p>		<p>16. SOCIAL SECURITY NO. W.W. # 2</p>		<p>17. INFORMANT MRS. THOMPSON - Rock Hall Md.</p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia</p> <p>819x DUE TO (b) Brain trauma</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pasenger of auto into fixed object</p>					
<p>20c. TIME OF INJURY Month, Day, Year 10/26/59</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street</p>			
<p>20f. (City or town) Rock Hall</p>		<p>(County) Kent</p>		<p>(State) Md.</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEP. JTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>SIGNATURE Russell S. Fisher M.D. DATE SIGNED 11/9/59</p> <p>EXAMINER'S NAME (Type) Russell S. Fisher, M.D. Address (Street, city, town, or county)</p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>		<p>22b. DATE THEREOF Nov. 11</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel</p>			
<p>22d. LOCATION (City, town, or country) Rock Hall</p>		<p>(State) Md.</p>		<p>23. FUNERAL DIRECTOR Edgar L. Lane - Church Hill, Ind.</p>			
<p>24a. REC'D BY REGISTRAR NOV 13 '59</p>		<p>24b. REGISTRAR'S SIGNATURE C. S. & K. K.</p>					



12366

Reg. Dist. No. _____

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown	LENGTH OF STAY (in this place) 22 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Thompson Avenue		STREET ADDRESS (If rural give location) Thompson Avenue	
3. NAME OF DECEASED (First) (Middle) (Last) Arthur Leonard Tinkler		4. DATE OF DEATH (Month) (Day) (Year) November 2 19 59	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH August 5 1882
9. AGE last birthday 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm manager	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Tinkler		14. MOTHER'S MAIDEN NAME Catherine Wornell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-3736	
17. INFORMANT & ADDRESS Arthur O Tinkler Reisterstown Md			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Cerebral Hemorrhage		8 hrs	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension & arteriosclerosis		years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Coronary Thrombosis		1958	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1-46 to 11-3-59 , that I last saw the deceased live on 11-3-59 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
SIGNATURE James H. Saffell		DATE SIGNED 11-4-59	
M.D. Reisterstown Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov 5/1959	
NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		LOCATION (City, town, or county) (State) Reisterstown Md	
24. REC'D BY REGISTRAR NOV 5 '59		25. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman & Sons	
DATE		ADDRESS Reisterstown	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12350

12203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK d. STREET ADDRESS 204 Chestnut St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First John Middle Caleb Last Toye				4. DATE OF DEATH Month Nov Day 28 Year 1959											
5. SEX M		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 14, 1918		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Steel plant				11. BIRTHPLACE (State or foreign country) Calvert Co. Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Edward Toyne						14. MOTHER'S MAIDEN NAME Katie Gorman									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs. Ann Toyne Nolley 612 Pitcher Street							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease, with aortic and mitral stenosis and regurgitation. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>W. Bradley King, Jr.</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						NOV. 29, 1959			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						NOV. 29, 1959									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORY Bethel Hill				22d. LOCATION (City, town, or county) Baltimore, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Frank</i>						ADDRESS <i>1631 E. Mount Vernon Ave.</i>				24a. REC'D BY REGISTRAR NOV 30 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 Y 01 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave		d. STREET ADDRESS 23 S. Wickham Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last William R. Valentine		4. DATE OF DEATH Month Day Year Nov. 16, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1887
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins University	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. J. Valentine		14. MOTHER'S MAIDEN NAME Ella Stitely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 213 03 0240	
17. INFORMANT Mrs. Jeannette Valentine		Address 23 S. Wickham Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS GENERALIZED 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) CARCINOMA ASCENDING COLON (c) 1 1/2 YRS			INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANEMIA PROFOUND			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 3 , 19 57 , to NOV. 16 , 19 59 , that I last saw the deceased alive on NOV. 16 , 19 59 , and that death occurred at 11:25 PM , from the causes and on the date stated above. DATE SIGNED John F. Schaefer M.D. 401 RANDOM ROAD BALTO. 29 MD. 11/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19/59	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE NOV 19 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 253 12-14-59 et

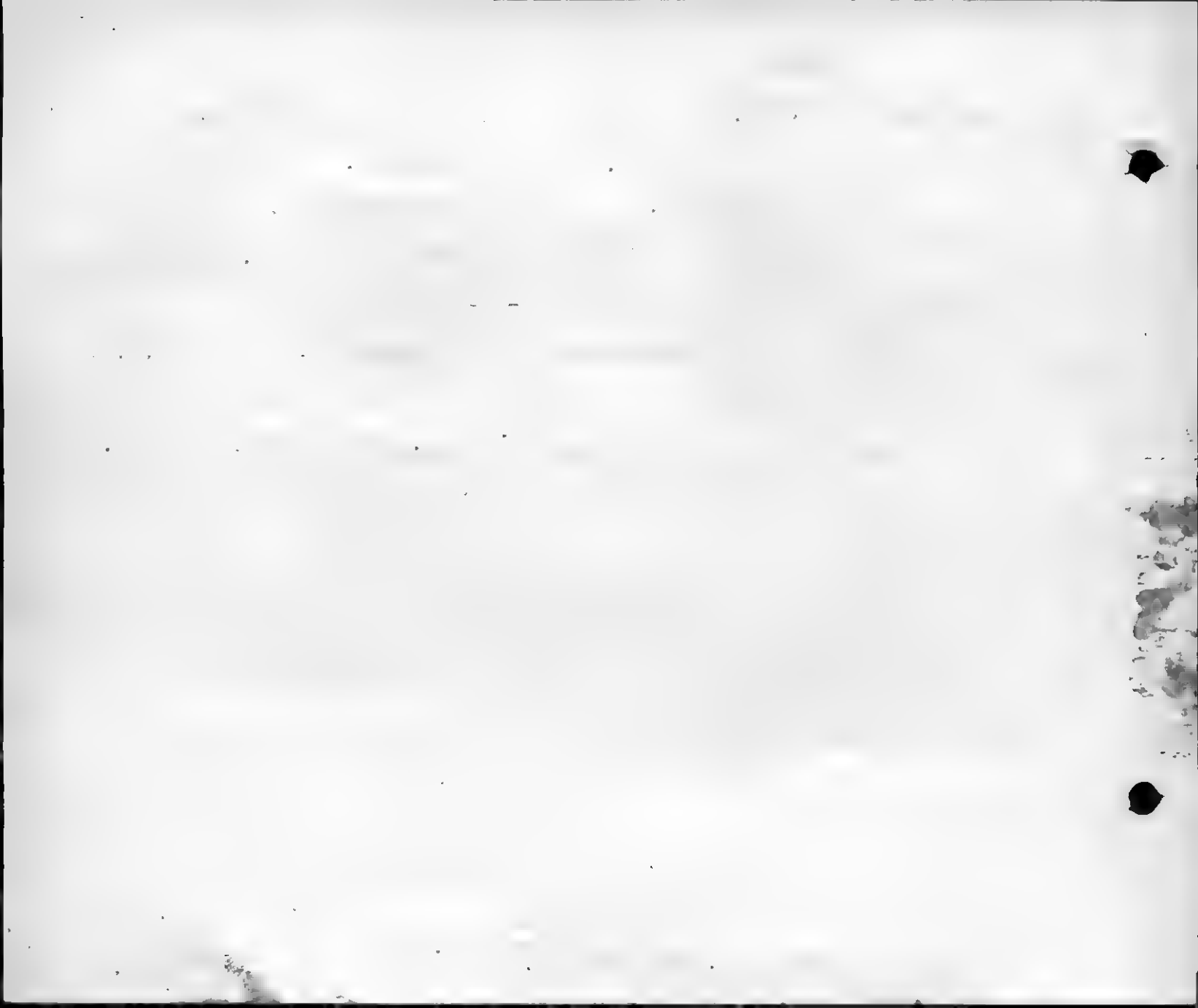
CERTIFICATE OF DEATH

12368

Reg. Dist. No.

12352

1. PLACE OF DEATH a. COUNTY Baltimore MD. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4,				c. LENGTH OF STAY IN lb 79yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1510 MAYWOOD AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle AURTHUR Last VAN HORN				4. DATE OF DEATH Month NOV. Day 21, Year SAT. 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-21-1882	
9. AGE (n years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 7 Days 21 Hours 0 Min 0		11. BIRTHPLACE (State or foreign country) RIDERWOOD MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of work no life even if retired) STONE MASON				10b. KIND OF BUSINESS OR INDUSTRY Construction			
13. FATHER'S NAME BENJEMIN VAN HORN				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO				16. SOCIAL SECURITY NO. 213-05-5251			
17. INFORMANT WILLIAM B. STONE				Address GREENGLADE RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 5 , 19 59 to Nov 21 , 19 59 that I last saw the deceased alive on Nov 21 , 19 59 , and that death occurred at 1 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 East Biddle Street DATE SIGNED 11/23/59							
ACTUAL SIGNATURE F. M. Dugan M.D.				DATE SIGNED 11/23/59			
PHYSICIAN'S NAME (Type) F. M. Dugan, M.D.				Baltimore 2, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		11-24-59		PROSPECT HILL		TOWSON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE BROOKS FUNERAL SER. 622 YORK RD.				24a. REC'D BY REGISTRAR DATE NOV 25 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Kane							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12369

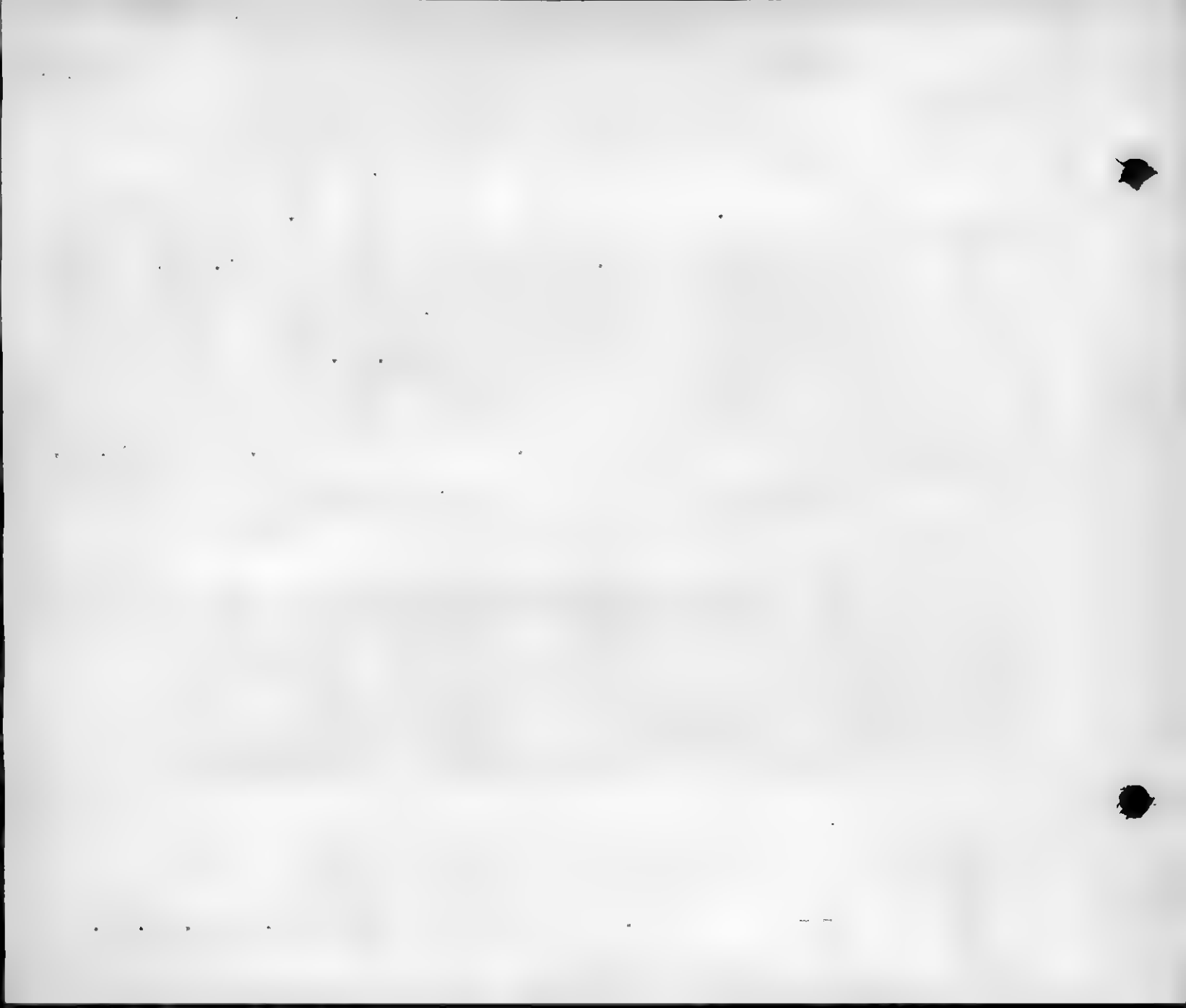
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12353

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ebenezer Rd.</u>			d. STREET ADDRESS <u>Ebenezer Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>M.</u> Last <u>Vincent</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1894</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Michael Dougherty</u>		
14. MOTHER'S MAIDEN NAME <u>Julia Martin</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mrs. Ida Gray Ebenezer Rd. White Marsh, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/30/59</u>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-1-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>	
22d. LOCATION (City, town, or county) <u>Fullerton, Balto. Co. Md.</u>		22e. (State) <u> </u>		22f. (Country) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine J. Hone</u>		ADDRESS <u>Home 7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		24c. (City, town, or county) <u> </u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12370

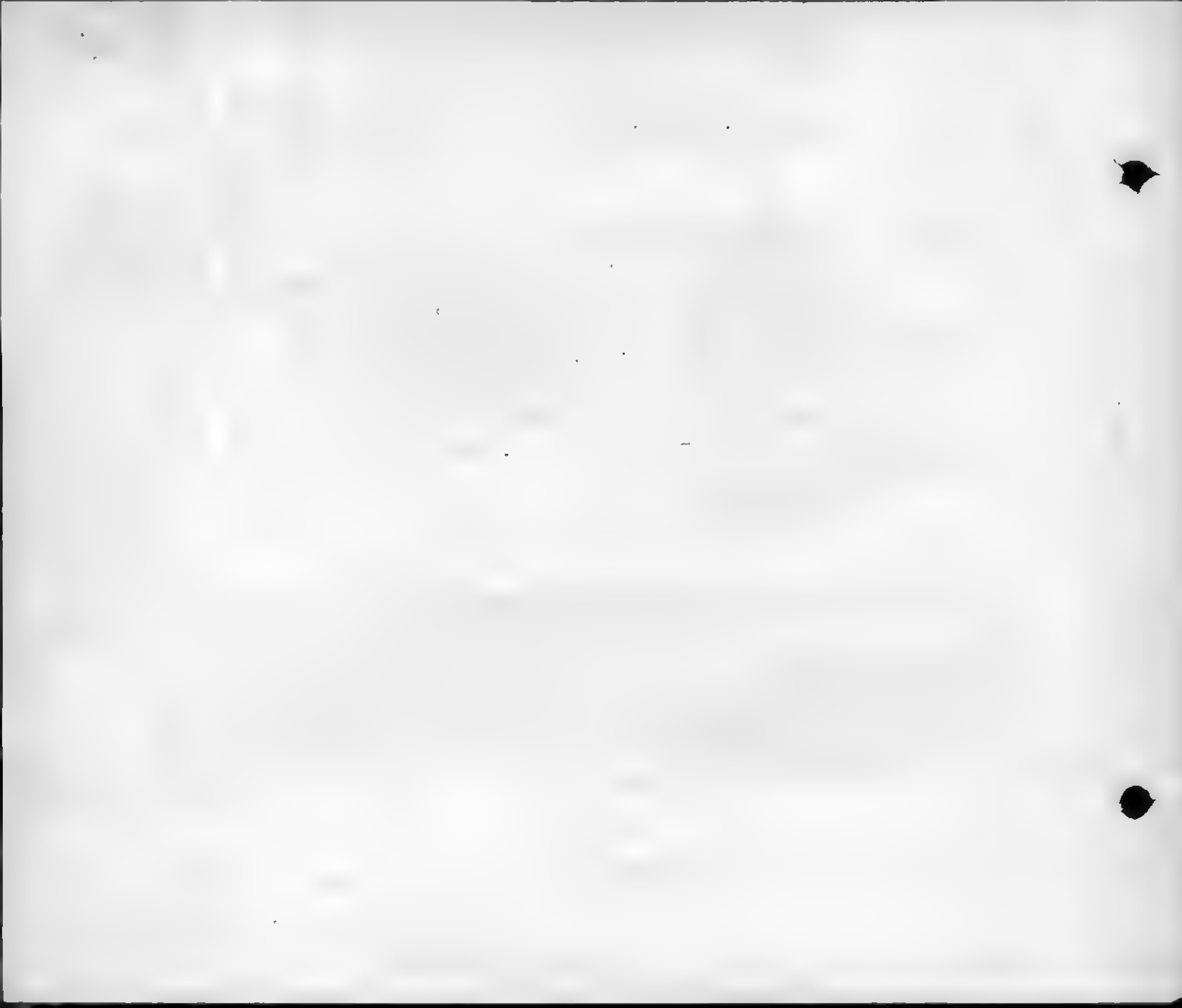
Item 12 Filed 11-30-59 at

CERTIFICATE OF DEATH

12354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co., 21, Md. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>703 Christian Avenue</u>				d. STREET ADDRESS <u>703 Christian Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Adolph</u>		First <u>J.</u> Middle <u>Waitkus</u> Last		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill-wright - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eastern Stain. Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-7793</u>		17. INFORMANT <u>Mrs. Mary Scharmer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Circulatory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of the lung</u> (c) <u>Emphysema thoracis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u> <u>3 days</u> <u>4 weeks final 2 months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema thoracis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-16</u> , 19 <u>59</u> , to <u>11-21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-20</u> , 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene C. Baumann</u>		ADDRESS (Street, city or town, state) <u>413 EASTERN AVE. ESSEX, MD</u>		DATE SIGNED <u>11/24/59</u>			
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>i Christine Brydych</u>				ADDRESS <u>1407 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. Haines</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12355

12371

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5 Paradise Avenue</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>5 Paradise Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr Thomas</u> First <u>Leonard</u> Middle <u>Walter</u> Last		4. DATE OF DEATH Month <u>November</u> Day <u>9th</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1886</u> 9. AGE (In years last birthday) <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Eng. General Motors</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles C. Walter</u>		14. MOTHER'S MAIDEN NAME <u>Harriet A. Poulton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-01-7628</u>	
17. INFORMANT <u>B Mrs. Alice Grimm</u> Address <u>2902 Owyer d. Balto.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>177x</u> DUE TO <u>Carcinoma of the Prostate</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Transurethral prostatectomy</u> (b) <u></u> (c) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Thos S. Kraus</u>	



CERTIFICATE OF DEATH

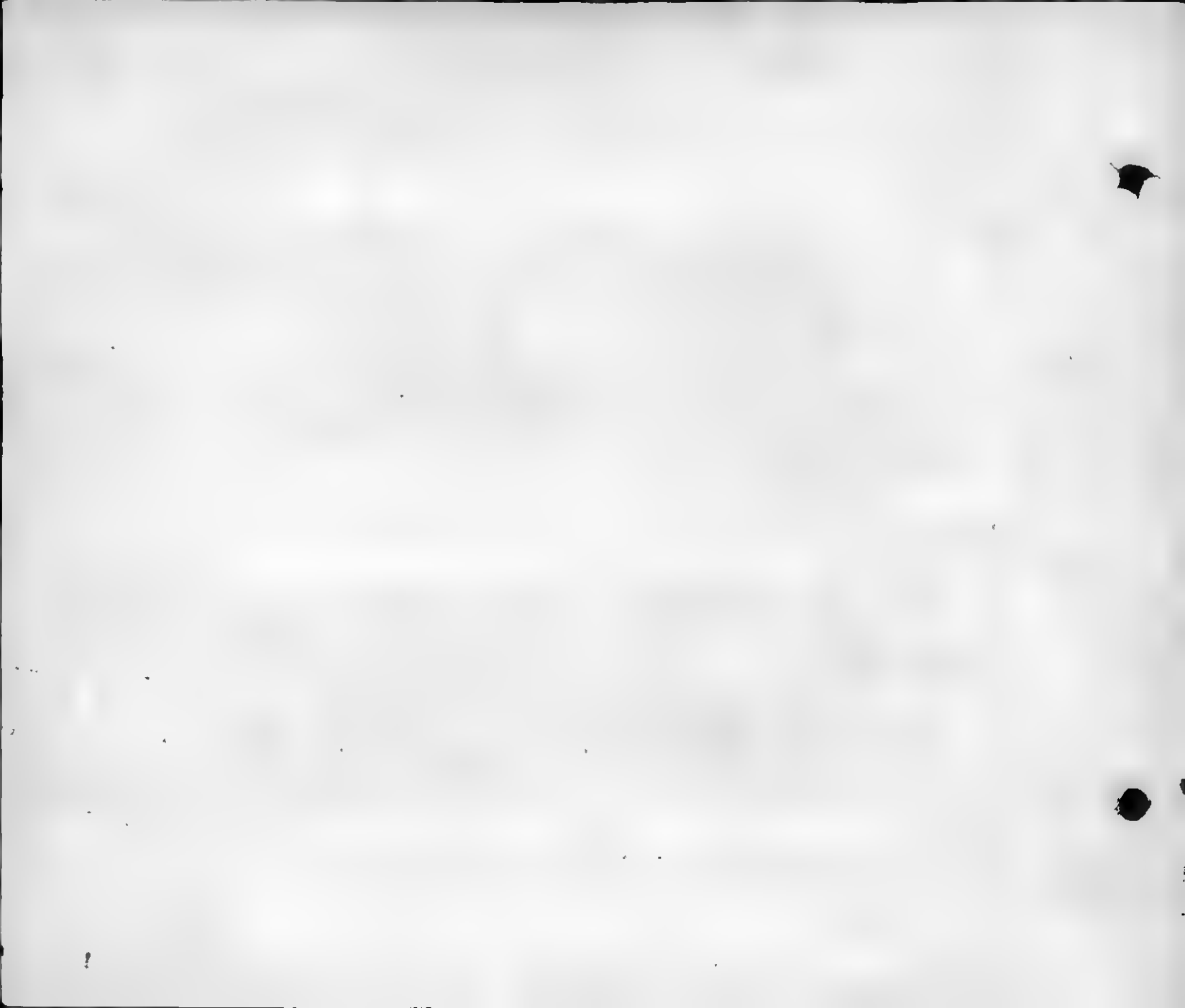
Reg. Dist. No. 12356

12372

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill, Maryland</u>	
c. LENGTH OF STAY IN TB <u>6yr11mth18dys</u>		d. STREET ADDRESS <u>Forest Hill, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>Ward</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Frederick Ward</u>	
14. MOTHER'S MAIDEN NAME <u>Cassie E. Heck</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-abdominal and pulmonary metastasis</u> <u>153.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the transverse colon</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 4</u> , 19 <u>59</u> , to <u>Nov. 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 24</u> , 19 <u>59</u> , and that death occurred at <u>7:15 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>11-25-59</u>	
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 27 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Chestnut Hill Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Arcey - Brown - Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Knecht</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 -

12373

CERTIFICATE OF DEATH

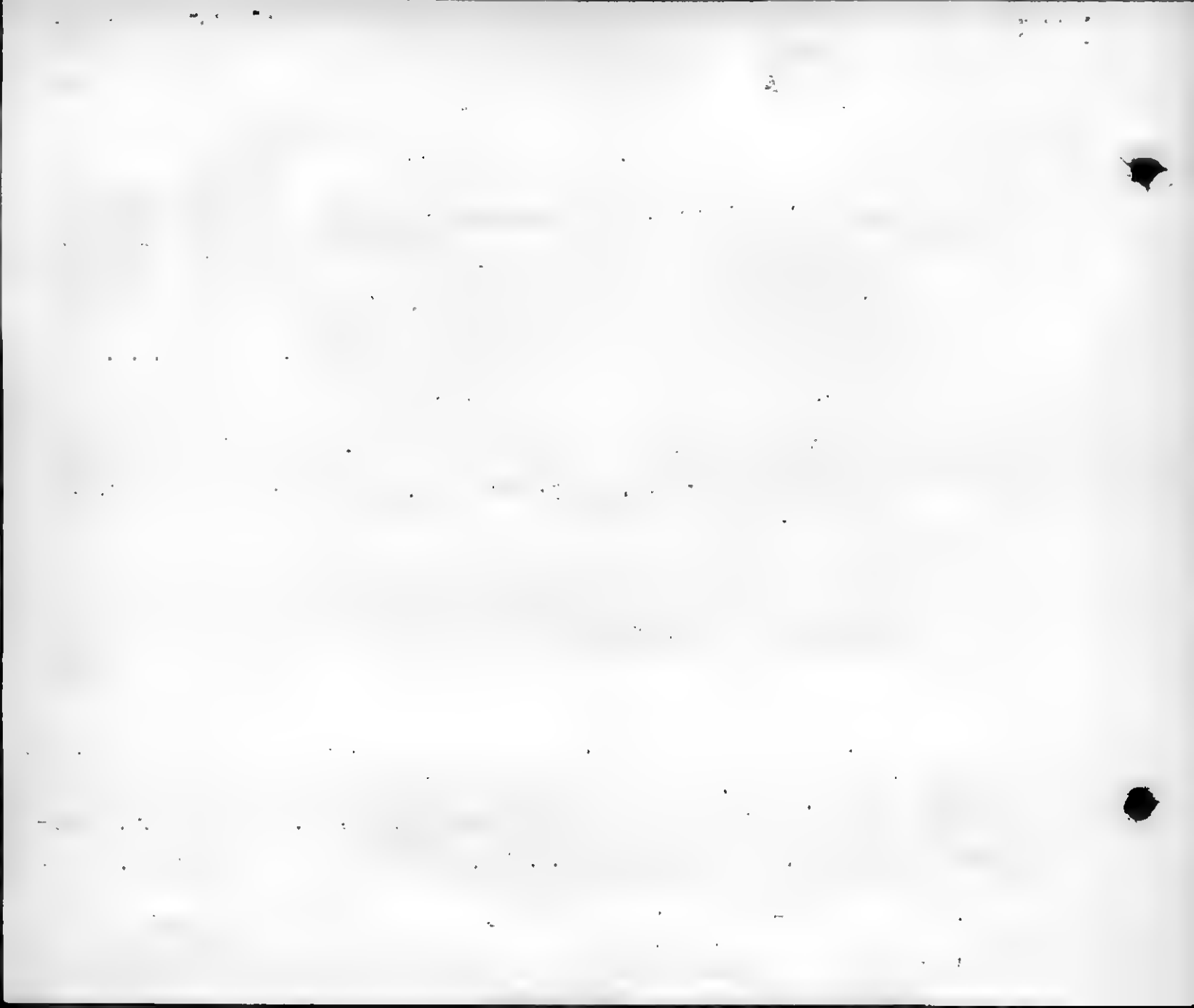
Reg. Dist. No.

12357

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1125 GORSUCH AVENUE	
3. NAME OF DECEASED (Type or print) First WALTER Middle W Last WARD		4. DATE OF DEATH Month November Day 25 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 19, 1920
9. AGE (In years last birthday) 39 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAND BLASTER	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER W. WARD		14. MOTHER'S MAIDEN NAME MOLLIE EISEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-11		16. SOCIAL SECURITY NO 213-12-2940	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GLIOMA OF THE LEFT TEMPORAL AND OCCIPITAL LOBES 193.0 INDEX OF BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) OF BRAIN		INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ENCEPHALOMALACIA; EDEMA OF LUNGS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from November 24, 1959 to November 25, 1959 and that the death occurred at 10:00 AM from the causes and on the date stated above. DATE OR 11-25-59 and the death occurred at 10:00 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Baltimore Md. - Ft Howard Div. DATE SIGNED 11-25-59			
ACTUAL SIGNATURE Clovis M. Snyder		M.D. VAH, Baltimore Md. - Ft Howard Div. 11-25-59	
PHYSICIAN'S NAME (Type) CLOVIS M. SNYDER		M.S. VAH, Baltimore Md - Ft Howard Div. 11-25-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-30-59	22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WM COOK-BLIGHT INC		ADDRESS 6009 Harford Road Baltimore 14 Md	
24a. REC'D BY REGISTRAR DEC 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12358

Reg. Dist. No.

12374

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex 21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1021 B Eastern Ave</u>		d. STREET ADDRESS <u>1021 B Eastern Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Evelyn</u> First <u>Wasson</u> Middle <u>Wasson</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OF FACE <u>gt</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-14</u> 9. AGE (In years last birthday) <u>45</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Va</u>
13. FATHER'S NAME <u>Art Stalhard</u>		14. MOTHER'S MAIDEN NAME <u>Agnes William</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>James Wasson</u> 17. INFORMANT <u>same</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>4 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 p. m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>59</u> , to <u>11-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. A. Castro, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>805 Fuselage Ave, Balto</u> DATE SIGNED <u>7-26-61</u>	
PHYSICIAN'S NAME (Type) <u>M. A. CASTRO, JR., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-11-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belk Cemetery</u>	22d. LOCATION (City, town or county) <u>Russell Co</u> (State) <u>Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James G. Smith</u> ADDRESS: <u>1407 Eastern Ave.</u>		24a. REG'D. BY REGISTRAR <u>NOV 12 59</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Carlton S. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

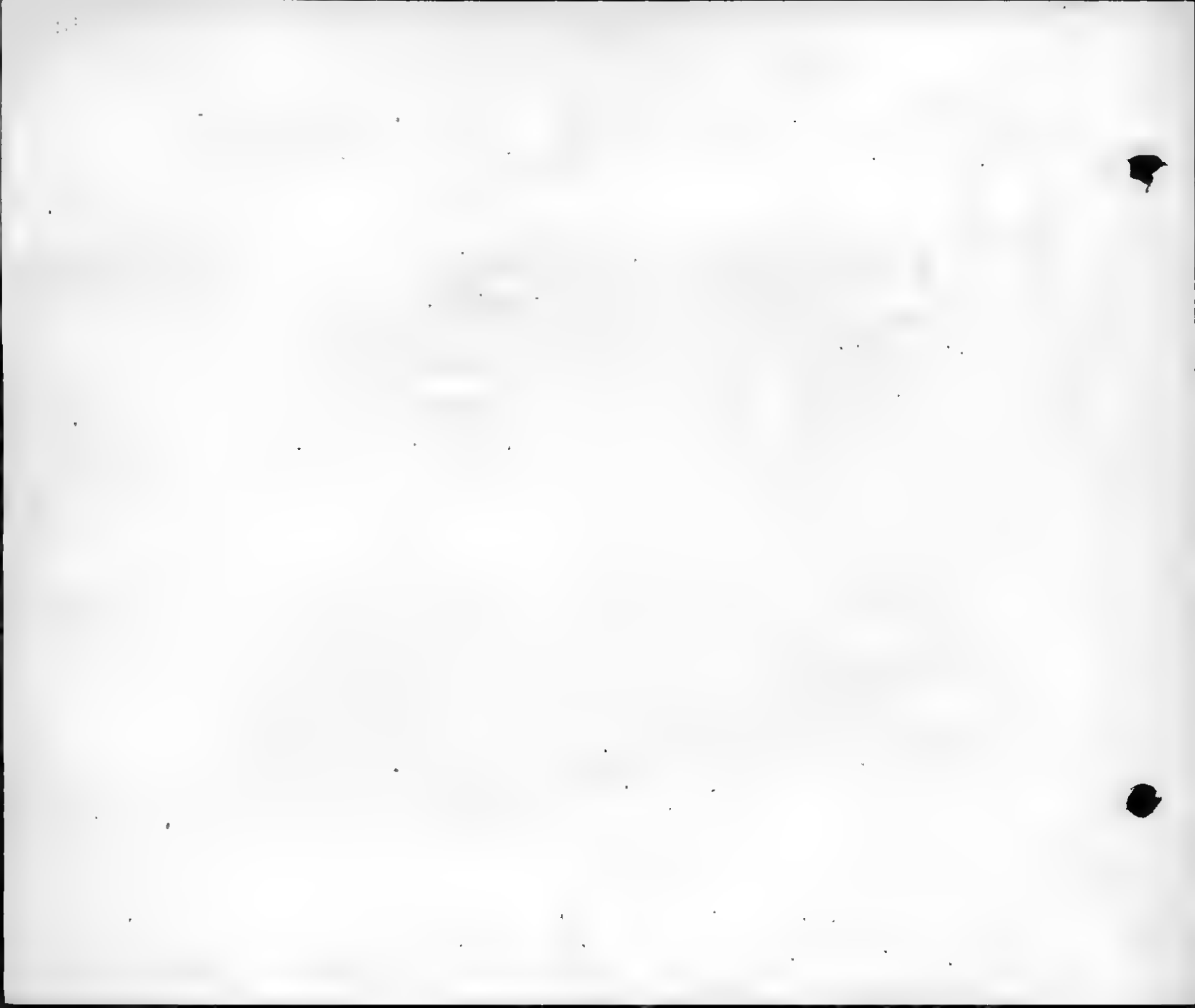
12359

12375

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Castleton Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E.</u> Last <u>Weber</u>		4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinery-Contractor Randallstown, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Weber</u>		14. MOTHER'S MAIDEN NAME <u>Mary Klohr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>219-10-1174</u>	
17. INFORMANT <u>Mrs. Florence Javer, Castleton Ave.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u> </u> DUE TO (c) <u> </u> DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>1957</u> to <u>Nov 6</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E McWilliams</u> M.D.		ADDRESS (Street, city or town, state) <u>Keisterstown Maryland</u> DATE SIGNED <u>Nov 8, 1959</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12360

12211

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands</u>		c. LENGTH OF STAY IN 1b <u>35 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Highlands</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2926 Ohio Ave.</u>				d. STREET ADDRESS <u>2926 Ohio Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis B. Heber</u> First Middle Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 23, 1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>		11. BIRTHPLACE (State or foreign country) <u>Prussia, Prussia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Heber</u>				14. MOTHER'S MAIDEN NAME <u>Manigault?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-329386</u>		17. INFORMANT <u>Mr. Agnes J. Heber</u>		Address <u>2926 Ohio Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broken neck, Fractured vertebrae</u> DUE TO <u>Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>970.0</u> DUE TO (c) <u>Vertebrae</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps inside of cellar</u>					
20c. TIME OF INJURY <u>3:45 P.M.</u> Month, Day, Year <u>11-28-59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Balto. Highlands</u> (County) <u>Balto. Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber</u>				ADDRESS <u>705 S. Chinn St</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. S. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No

12376

12361

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5900 Cecil Ave		d. STREET ADDRESS 5900 Cecil Ave	
3. NAME OF DECEASED (Type or print) First Helen Middle A. Last Weil		4. DATE OF DEATH Month Nov. Day 19 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 19 1907
9. AGE (In years last birthday) 52		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Baltimore Co. Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert H. Keith		14. MOTHER'S MAIDEN NAME Elizabeth Hood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret Healey, Catonsville, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion = Myocardial Infarction DUE TO (c) 6 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 14 , 19 59 to Nov 19 , 19 59 , that I last saw the deceased alive on Nov 19 , 19 59 , and that death occurred at 11:30 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl Pass		ADDRESS (Street, city or town, state) 4001 Wilkens Avenue	
PHYSICIAN'S NAME (Type) Earl Pass, M. D.		DATE SIGNED Nov 11-20-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORY Lorraine	22d. LOCATION (City, town, or county) (State) Woodlawn, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN THE

OF THE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12377

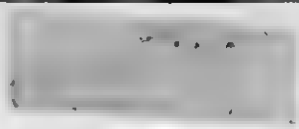
CERTIFICATE OF DEATH

Reg. Dist. No. **12362**

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 46 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY (7) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4010 Liberty Heights Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PHILIP Middle ---- Last WEINBERG		4. DATE OF DEATH Month November Day 2 Year 1959	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH November 10, 1905
9. AGE (In years last birthday) 53		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver 10b. KIND OF BUSINESS OR INDUSTRY Taxicab 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Weinberg		14. MOTHER'S MAIDEN NAME Selina Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give or dates of service) WW II		16. SOCIAL SECURITY NO 705-10-0553 INFORMANT Clin. Records, VAH, Balto. 18, Md. Fort Howard Division	

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT MAIN BRONCHUS WITH METASTASES TO HILAR AND PERIAORTIC LYMPH (b) NODES, RIGHT LUNG, 6TH LEFT RIB AND LIVER (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO				INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Slight hypertrophy, left ventricle, heart.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 17, 1959</u> to <u>November 2, 1959</u>, and that death occurred at <u>10:25 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIVISION DATE SIGNED 11/3/59					
ACTUAL SIGNATURE <i>John W. Crawford</i>		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-4-59		22c. NAME OF CEMETERY OR CREMATORY <i>Herring Run</i>	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc.		ADDRESS 3x 2100 Eutaw Place, Balto. Md.		DATE NOV 4 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



1 X.
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12363

12204 Item 9 Film G253 12-14-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3110 Cornwall Road</u>		d. STREET ADDRESS <u>107 S. Patomac Street</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Mary</u> First Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 2, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kearin Coughlin</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Murdock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Miss Margaret Welsh</u> Address <u>107 S. Potomac St.</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack O. Collen</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack O. Collen</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore Street</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

12364

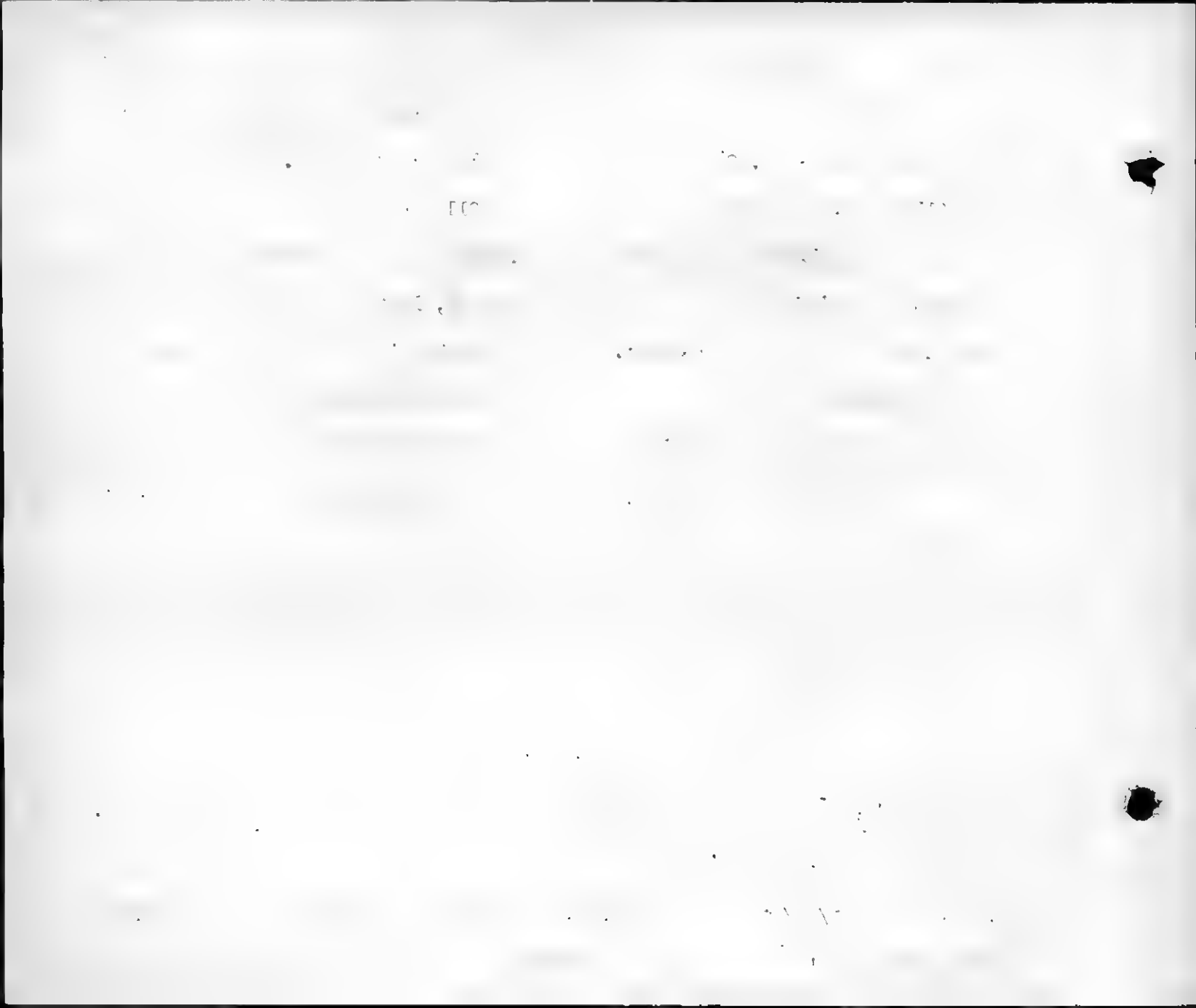
Reg. Dist. No.

12378

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) IDLEWYLDE (BALTO. 12)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6311 BEECHWOOD ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH WARWICK WHITNEY				4. DATE OF DEATH Month Day Year NOVEMBER 11 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 24, 1896	
9. AGE (In years last birthday) 63 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME OTWAY WARWICK		14. MOTHER'S MAIDEN NAME ELIZABETH GORDON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma, left DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 mos							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1959 to Nov. 11, 1959 that I last saw the deceased alive on Nov. 7, 1959 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. P. Benson, Jr.		DATE SIGNED 3506 N. Calvert St., Balto., Md. 11/12/59					
PHYSICIAN'S NAME (Type) W. P. BENSON, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/13/59		22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS TOWSON MARYLAND		24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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12379

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12365

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md.		c. LENGTH OF STAY IN 1b July 14, 1959	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AGED WOMEN'S AND MEN'S HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie Lara Cientes		4. DATE OF DEATH Nov. 19 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1880
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Registered Nurse	11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Fredrick C. Winters	
14. MOTHER'S MAIDEN NAME Mary Oymal		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Daisy E. Hamilton, 615 Chestnut Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable myocardial infarction 4.5.1 DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO hypertension; brachial (c) cholesterol deposits			INTERVAL BETWEEN ONSET AND DEATH Days year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Nov. 19, 1959 , and that death occurred at P. A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William H. Kirby, Jr.		ADDRESS (Street, city or town, state) 1526 Thacker Road, Baltimore 12, Md.	
PHYSICIAN'S NAME (Type) William H. Kirby, Jr.		DATE SIGNED Nov. 19, 1959	
22a. BURIAL, CREMAT., OR REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-21-59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR NOV 20 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

12380

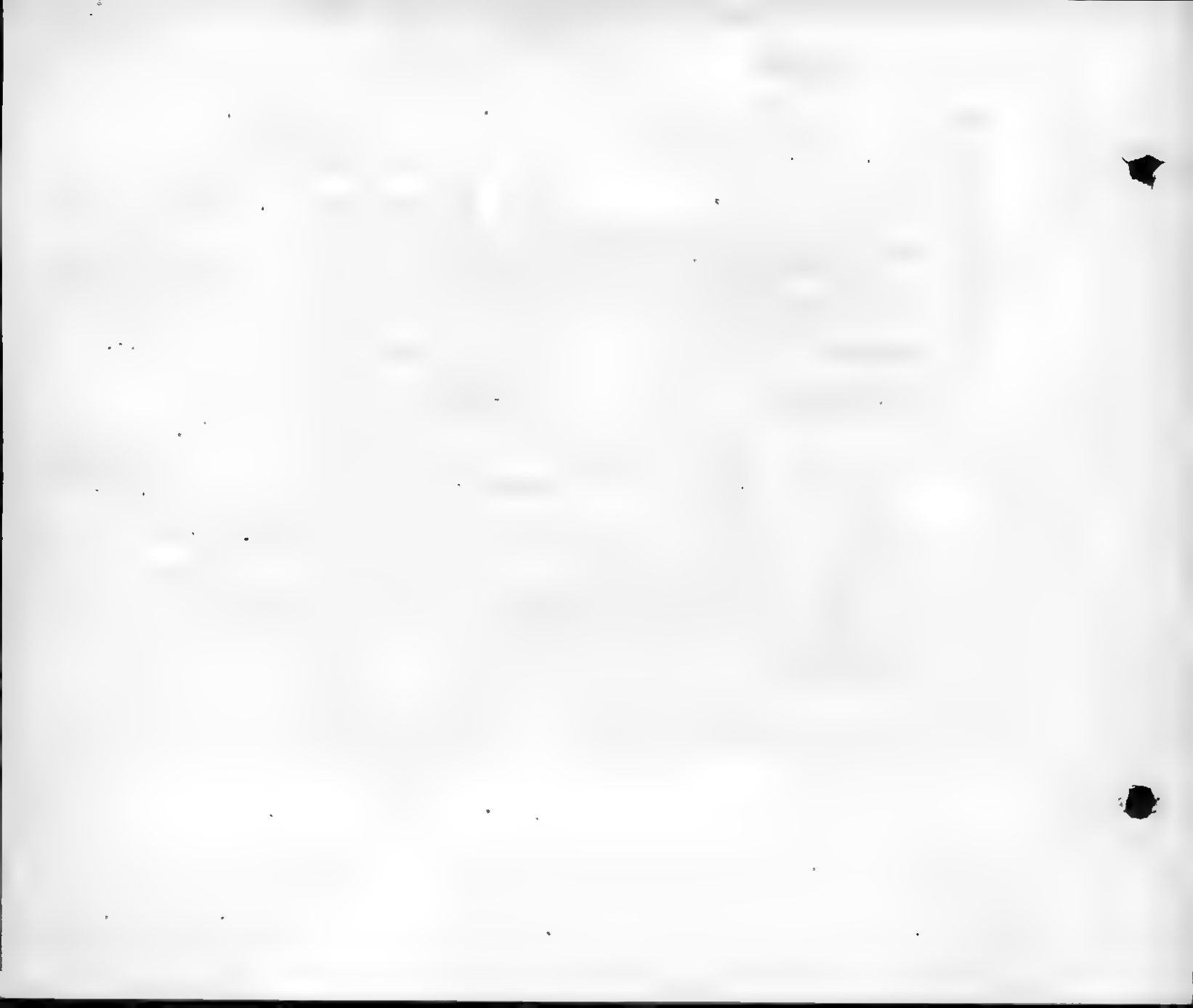
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Fullerton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 312 Trumps Mill Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick C. Middle Wolf Last				4. DATE OF DEATH Month 11 Day 26 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/3/1877	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Retired				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George M. Wolf				14. MOTHER'S MAIDEN NAME Frederick Vogt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 212-01-6865		INFORMANT Address John Wolf Box 312 Trumps Mill Rd. #6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO arteriosclerotic Cardiovascular disease 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 59 , to 11/26 , 19 59 that I last saw the deceased alive on Nov 25 , 19 59 and that death occurred at 10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 11/27/59 ACTUAL SIGNATURE G M Baumgardner PHYSICIAN'S NAME (Type) G. M. Baumgardner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE DEC 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

MEDICAL CERTIFICATION

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58



12381

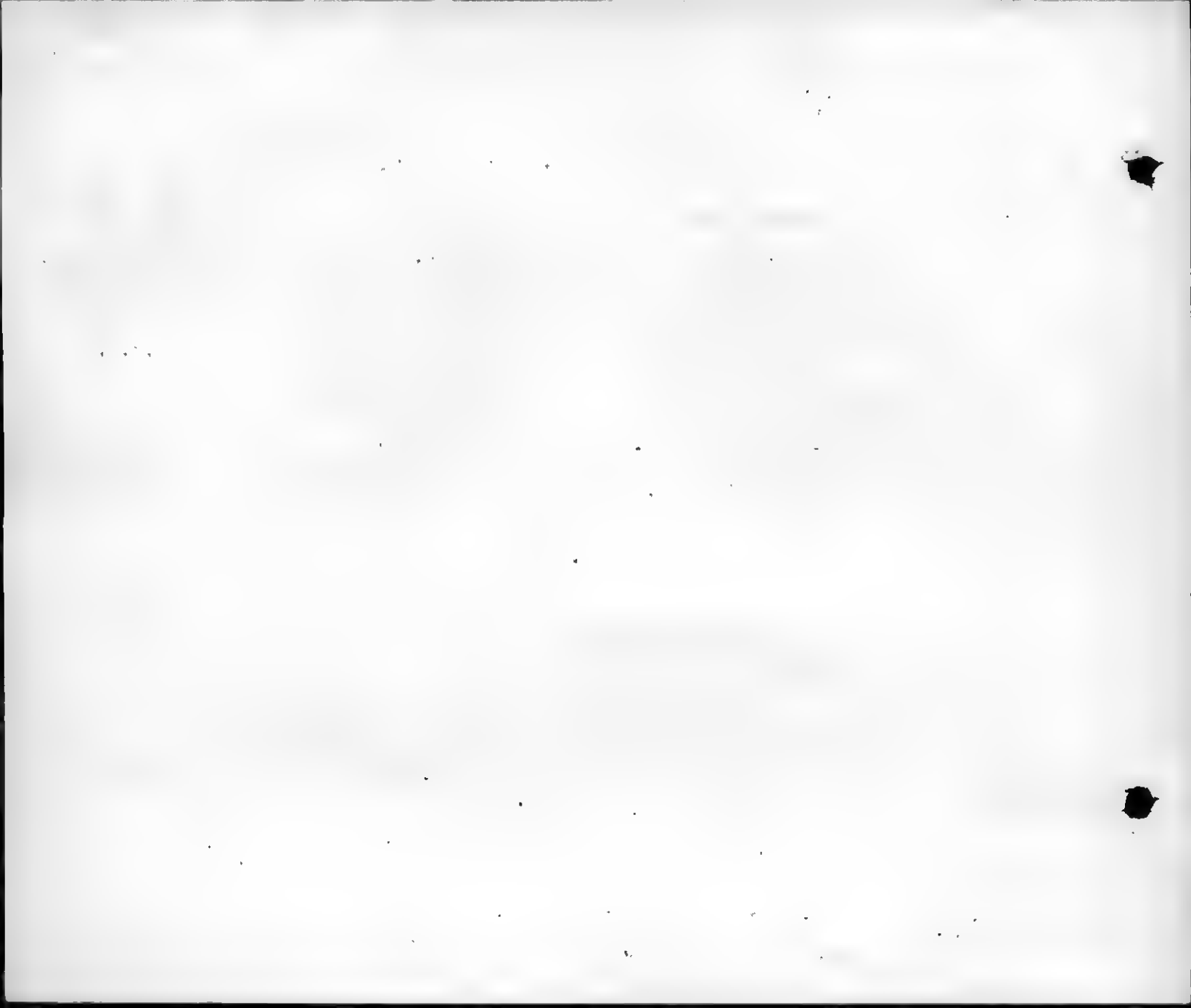
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <u>Rosewood State Training School</u> a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 30, Maryland</u>	
c. LENGTH OF STAY IN TB <u>6 yrs. 4 mos.</u>		d. STREET ADDRESS <u>1634 East Fayette Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ivan</u> Middle <u>Neal</u> Last <u>Woods, Jr.</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/49</u>
9. AGE (In years lost birthday) <u>10</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ivan Neal Woods</u>		14. MOTHER'S MAIDEN NAME <u>Norma Lee Stevens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Rosewood Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Grand mal seizure</u> DUE TO (b) <u>Epilepsy</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:00 a. m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ped w Rieckert</u>		ADDRESS (Street, city or town, state) <u>4307 Mainfield Dr Baltimore 14, Md</u>	
PHYSICIAN'S NAME (Type) <u>Ped w. Rieckert</u>		DATE SIGNED <u>11/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc. Preston & St...</u>		24a. REC'D BY REGISTRAR <u>NOV 20 1959</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

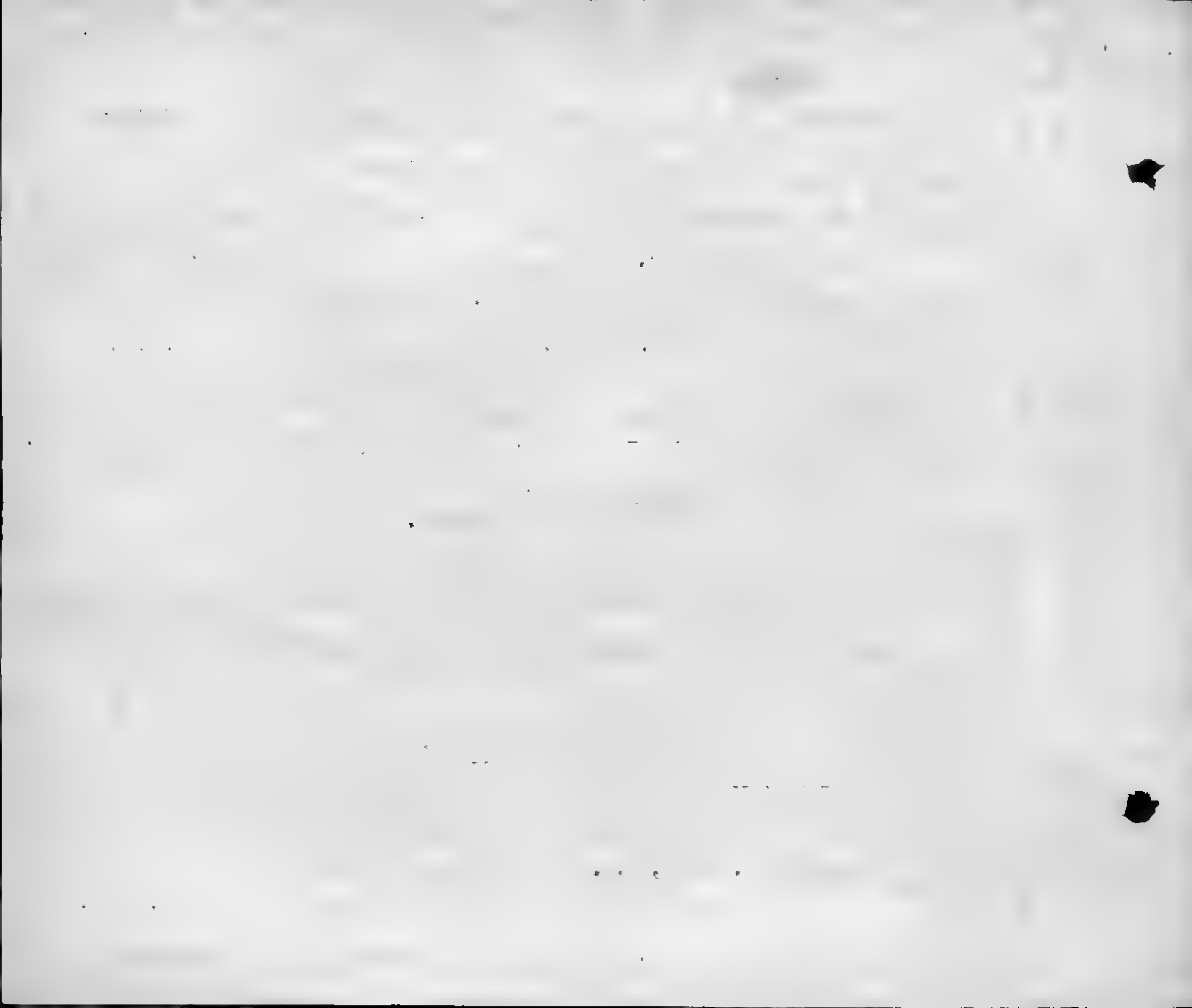
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12368

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN TB 8 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Res, 6927 Holabird Avenue		d. STREET ADDRESS 6927 Holabird Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES J. WRIGHT		4. DATE OF DEATH November 3 19 59		5. SEX Male	
6. CO. OR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1919	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Penna. RR Co.		9. AGE (In years last birthday) 40	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest Wright	
14. MOTHER'S MAIDEN NAME Mabel Rasicot		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes Army WW II		16. SOCIAL SECURITY NO. 213-10-4171	
17. INFORMANT Mr. Jack Wright		Address 35 Mavista Ave. 22, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). Myocardial Infarction		DUE TO Coronary Artery Thrombosis.		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/4/59	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1959	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		22d. LOCATION (City, town, or country) (State) German Hill Rd. Md.		23. FUNERAL DIRECTOR John J. Duda	
ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12382

Reg. Dist. No.

12369

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b DAYS 24 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whitehall, Md d. STREET ADDRESS 12X	
3. NAME OF DECEASED (Type or print) First LESLIE Middle WRIGHT Last WRIGHT		4. DATE OF DEATH Month Nov. Day 14 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 31-1878
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKMAN	10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME UNKNOWN RICHARD WRIGHT		14. MOTHER'S MAIDEN NAME UNKNOWN MARY ELLEN REED	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Hospital's Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Arterio-sclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) attempted suicide Sept 25 1959 cut throat with razor blade			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) unable to repair damage. tracheostomy performed	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) still breathing tube	20f. (City or town) Whitehall (County) Harford (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S. M. Kieffer		DATE SIGNED Nov. 15 59	
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Nov 17, 1959	22c. NAME OF CEMETERY OR CREMATORY Green Chapel	22d. LOCATION (City, town, or county) White Hall (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Kieffer		24a. REC'D BY REGISTRAR NOV 20 59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

MEDICAL CERTIFICATION



12383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>				c. LENGTH OF STAY IN 1b <u>2 WKS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD STATE TRAINING SCHOOL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>LUCILLE</u> Last <u>YEATER</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-27-16</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHARLES WESLEY YEATER</u>		14. MOTHER'S MAIDEN NAME <u>INA DORVEY LAWSON YEATER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>ROSEWOOD RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism com.</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>plicated by aspiration of</u> DUE TO (c) <u>stomach content</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>11/3</u> , 19 <u>59</u> , to <u>11/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>59</u> , and that death occurred at <u>2:00 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Pet W. Rieckert</u> M.D.				ADDRESS (Street, city or town, state) <u>4307 Main</u> DATE SIGNED <u>11-15-59</u>			
PHYSICIAN'S NAME (Type) <u>P. W. Rieckert</u>				<u>Baltimore</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-18-59</u>		<u>Lumberport Cem.</u>		<u>Lumberport, W. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers, Jr.</u> <u>19 Jesse St.</u>				24a. REC'D BY REGISTRAR <u>NOV 18 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

1. 2. 3. 4.

CERTIFICATE OF DEATH

Reg. Dist. No.

12371

12384

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN TB <u>2 mo. 7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
f. STREET ADDRESS <u>6901 FAIR AVE.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEON</u> First Middle Last <u>ZIEMSKI</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/17</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ZIEMSKI</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE DUMBROSKI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or date of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>218325055</u>	
17. INFORMANT <u>RECORDS; SPRING GROVE Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nodular Cirrhosis of the liver</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-7</u> , 19 <u>59</u> , to <u>11-14-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-14</u> , 19 <u>59</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Jose R. Arizaga M.D.</u> M.D. <u>Spring Grove State Hosp.</u> <u>Nov. 15, 1959</u>			
PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA</u> <u>Catonville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. F. SADOWSKI & SONS</u> ADDRESS <u>1808 EASTERN AVE</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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